DRUG ABUSE TREATMENT AND PREVENTION PROVISIONS OF THE ANTI-DRUG ABUSE ACT OF 1986

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

MARCH 11, 1987

Printed for the use of the
Select Committee on Narcotics Abuse and Control

SCNAC-100-1-3

U.S. GOVERNMENT PRINTING OFFICE
76-296 WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H96-48

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DRUG ABUSE TREATMENT AND PREVENTION PROVISIONS OF THE ANTI-DRUG ABUSE ACT OF 1986

WEDNESDAY, MARCH 11, 1987

House of Representatives,
Select Committee on Narcotics Abuse and Control,
Washington, DC.

The committee met, pursuant to call, at 9:43 a.m., in Room B-352, Rayburn House Office Building, the Honorable Charles B. Rangel (chairman of the committee) presiding.

Present: Representatives Charles B. Rangel, Benjamin A. Gilman, Michael G. Oxley, James H. Scheuer, Walter E. Fauntroy, F. James Sensenbrenner, Stewart B. McKinney, Robert K. Dornan, and Joseph J. DioGuardi.

Staff present: Edward Jurith, Staff Director; Elliott Brown, Minority Staff Director; George Gilbert, Counsel; Michael Kelley, Counsel; Rebecca Hedlund, Press Officer; Jack Cusack, Consultant; and Jehru Brown, Investigator.

STATEMENT OF CHARLES B. RANGEL, CHAIRMAN, SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

The Chairman. I apologize for being delayed and for any inconvenience it may have caused my colleagues and the witnesses.

Today, the Select Committee on Narcotics Abuse and Control continues its series of hearings to review the implementation of the Omnibus Anti-Drug bill that we passed last year.

The focus this morning will be on treatment and prevention. And these provisions are administered by the Alcohol, Drug Abuse and Mental Health Administration in the Department of Health and Human Services.

Other sections of the Act deal with reducing drug supply through enforcement, interdiction and international narcotics control and preventing drug use through comprehensive drug abuse education programs. But it is in these sections that we attempt to see what we will be doing to give a much needed assistance to drug addicts and drug-dependent persons.

From 1980 to 1986, the Federal support for drug abuse and prevention have dramatically declined. During the same period, of course, the supplies of drugs have dramatically increased. Cocaine deaths and overdoses have more than tripled; heroin overdose deaths and emergency room episodes have jumped sharply. And in urban communities, as we all know, it's a very serious problem.

The increased availability of cheaper drugs, "Black Tar" heroin and "Crack," have added new dimensions to this problem. And in many parts of the country, including my own city, they have long waiting lines for service, notwithstanding the fact that government, including local, state, and federal, encourage people to get treatment and such treatment, many times, is not available.

The Administration has long felt that this has been a local and state problem, and has denied a federal responsibility to help local and state governments combat this problem.

But nevertheless, the Congress has moved in the Anti-Drug Bill to try to provide funds for the expanded local and state needs. The Anti-Drug Abuse Act also established a new Office of Substance Abuse, and to expand the agency's role in training, technical assistance, information development and dissemination of information.

Also for research for new initiatives and expanding our knowledge.

We will attempt, not only to review how the Act is taking place, but more importantly, to get the Administration's view as to what is going on. Have the monies that have been made available been used, what are the ideas that the Administration has now, and whether or not the signing into law of this Act makes any difference at all in the attitudes about whether or not this is a local or a federal problem.

[The opening statement of the Chairman appears on p. 43.]

The CHAIRMAN. Now, the Chair invites Wayne Lindstrom, who is the Co-Chairperson, Committee on Public Policy, National Association of State Alcohol and Drug Abuse Directors, and the Chief, Bureau of Alcohol Abuse and Alcoholism Recovery from the Ohio Department of Health to come forward as well as, on this panel, Karst J. Besteman, Executive Director of Alcohol and Drug Problems Association of North America.

And I will now recognize any Member that may have an opening statement.

Mr. SCHEUER. Mr. Chairman?

The CHAIRMAN. Mr. Scheuer.

STATEMENT BY THE HONORABLE JAMES H. SCHEUER

Mr. SCHEUER. It's evident from the 15 years of history that we've experienced, that I know about having served on this Committee for that period of time, that we're not going to be able to control drugs either through eradication of the fields in which they're grown abroad in all parts of the developing world, nor are we going to be able to make definitive progress in the field of interdiction.

It's an impossible job. We cannot lower our effort. We must continue, unremittingly. But we're going to have to look to our efforts in this country at the other end of the spectrum, at the demand end, to reduce the demand through drug education and to treat and educate those people who are addicted.

So I consider this morning of testimony an extremely significant morning of testimony. It is in the areas of treatment and education and prevention that the hope for the future lies.

So I welcome your testimony.

The CHAIRMAN. Mr. McKinney.

STATEMENT BY THE HONORABLE STEWART B. McKINNEY

Mr. McKinney. Well, Mr. Chairman, I just wanted to reiterate your remarks about the national scope of this problem. Typhus, cholera, you name it, they're not limited by state boundaries.

Interstate drug traffic is not the only problem. An equally serious problem is the fact that drugs are crossing our national border. If ever you needed proof of that, I think it was yesterday's arrest of the Pan American 25 who have brought in what is estimated to be over $1.5 billion worth of cocaine into the United States. Kennedy Airport may belong to New York but New York doesn't control where planes go or what people do.

The drugs that are killing our kids are coming into the United States of America and should be so treated. No state can wall off their boundary like the East Germans did. And we wouldn't tolerate it if they tried.

But the fact of the matter is we are the problem. And it's the United States Government that has the ability and the options, and, most certainly, not real money, but money to conquer this problem and we've got to do it because it's a national threat.

It's not an Ohio threat or a Connecticut threat, it's a national threat.

And I'm delighted you're having these hearings. And I think the first thing that we've got to recognize is that drug addiction is a federal problem. It's a problem of our mores of our nation, of our Air Force and Navy and Army, and everybody else, and we've got to do something about it.

Thank you very much, Mr. Chairman.

The Chairman. Thank you.

Yes?

STATEMENT BY CONGRESSMAN WALTER E. FAUNTROY

Mr. Fauntroy. Mr. Chairman, I want to compliment you for your unceasing and thorough examination of one of the most critical issues of this 100th Congress, the failure of the Reagan Administration, in spite of all its rhetoric about drug prevention and treatment, to support through the 1988 budget the needs outlined in the Omnibus Drug Abuse Act of 1986.

This hearing to examine the implementation of that Act in the areas of treatment and prevention is an important opportunity to highlight and emphasize the need versus the present capacity of treatment to meet that need.

Treatment and prevention in the Anti-Drug Abuse Act of 1986 provided minimally for only emergency needs in this area. Presidential budget appropriations for fiscal year 1988 provide the most token, the most meager recognition of that crisis.

Instead of increasing what was already an inadequate funding for treatment, we find a complete disregard for the whole crisis and the most cynical tokenism.

There are real questions to be asked and answered in this area of treatment.

First, what is our present national treatment capacity and what kinds of facilities and modalities are available at state, county and city levels?

What is the actual count, by narcotic identification, of the cases in need of treatment: how many heroin cases, how many cocaine cases, how many PCP cases?

Are we meeting these goals of treatment?

What is available in research in treatment modalities? Are we properly funding research at the National Institutes of Drug Abuse and other health agencies to meet the challenges of this escalating malady of substance abuse?

How much money is actually presently available to local and state jurisdictions for treatment?

How much money is actually needed to meet the future demands of treatment?

And are we really exploring additional sources of revenue to assist funding of treatment?

These are just a few of the questions that I hope will be answered in this morning's hearing.

I would add two other population groups that somehow never get the emphasis that they should. First, our prison populations with the tragic needs for treatment that presently are not being met.

And, secondly, the drug user who the military tells us they "return immediately to general society from military service with no attempt at treatment in the services." What are we doing to save these young people through treatment?

We must face our humane and moral responsibility as informed and empowered legislators in this area of funding for treatment and prevention.

I know many of my colleagues join me in this urgent plea, and I know that the amount of suffering in every social strata of the American family cries out for our assistance.

So let us move to establish real facts, real figures, and real counts of what is needed. And then let us, as a Committee, demand the amount of money needed to bring about this level of treatment and prevention relief as quickly as possible.

I thank you, Mr. Chairman.

[The statement of Mr. Fauntroy appears on p. 48.]

The CHAIRMAN. Thank you, Congressman.

The Chair recognizes the Ranking Minority Member, Mr. Gilman.

STATEMENT BY THE HONORABLE BENJAMIN A. GILMAN, RANKING MINORITY MEMBER

Mr. GILMAN. Thank you, Mr. Chairman. And I welcome the opportunity of hearing the testimony by our good witnesses today. This is our third Oversight Hearing of the Anti-Drug Abuse Act of 1986 which will focus on existing and new federal efforts in the area of substance treatment and prevention.

I don't think it's any secret that the numbers of those abusing illicit substances continues to rise while the price of those substances goes down. The problem has escalated dramatically in recent years, requiring an additional effort over and above what has already been instituted.

In hearing after hearing, our Select Committee has learned of lengthy waiting lists for treatment and prevention across the nation. I think it is a sorry state of affairs when one finds an individual honest and frank and committed enough to enter a program of rehabilitative therapy only to find scores of others standing in line ahead of him.

What does this say about our present system?

We encourage people to quit and say no, we assure them that help is on the way and then leave that individual dangling sometimes for weeks and months on end.

These are the people who need the assistance the most and instead, they're losing the most. And what is being lost is faith in the commitment and integrity of those who have the ability to offer assistance.

This vicious cycle has to be broken and solutions are going to have to be addressed. And hopefully, in this morning's discussion, we'll find some of those solutions available.

Congress certainly remains thoroughly committed to helping our states and our local governments in administering their treatment and their prevention programs. Not only funding is at issue, new modalities and technical expertise have to be made available.

The new Office of Substance Abuse Prevention in ADAMHA has been given a very important role in our "war on drugs," and I am keenly interested in being apprised of its agenda, timetable, and demonstration projects.

We look forward to hearing from our distinguished witnesses this morning. I hope that they're going to be able to provide our Select Committee with candid assessments as to how our nation can best treat and rehabilitate those who have become victims to the illicit trafficking that has been flooding our shores.

Clearly, the lack of fiscal year 1988 funds, as proposed by the Administration, cannot be left to stand. We negate our own efforts to help combat drug abuse if we insist that funding for one year be made to last for two years.

And more importantly, such a perspective negate what we know to be the reality of the very serious drug crisis in our own nation.

Thank you, Mr. Chairman.

[The statement of Mr. Gilman appears on p. 52.]

The CHAIRMAN. Thank you, Mr. Gilman.

Mr. Lindstrom? I might point out, if there's no objection from the Committee, that both of your statements will be entered into the record in its full text. And you may highlight it if you want.

Mr. Lindstrom.

TESTIMONY BY WAYNE LINDSTROM, PH.D., COCHAIRPERSON, PUBLIC POLICY COMMITTEE, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS

Mr. LINDSTROM. Thank you very much, Mr. Chairman, and Members of the Committee.

I appreciate this opportunity to address the Committee on the status of the Anti-Drug Abuse Act of 1986 and to offer to you our grave concerns regarding the President's proposed budget for fiscal year 1988.

My name is Wayne Lindstrom and I am testifying before you as the Co-Chairman of the Public Policy Committee of the National Association of State Alcohol and Drug Abuse Directors.

And I serve as Chief of the Bureau on Alcohol Abuse and Alcoholism Recovery.

To allay any concerns the committee might have with my title in the alcohol arena, I just might add that I started out in this business roughly 17 years ago when Congress was concerned about the drug problem coming out of Vietnam.

And as a young second lieutenant in the United States Air Force, I found myself, as a result of that initiative, directing one of the first drug treatment programs in the military to begin to address that problem.

I've been involved in both alcohol and drug issues ever since. And within the State of Ohio, while we still have two separate authorities for alcohol and drug abuse, two years ago we moved the two bureaus into the same office and have created bureaucratic heresy by functioning as a single entity to the limits the bureaucracy will allow.

NASADAD, I'm sure you are aware, is a National Organization of State Alcohol and Drug Abuse Authorities. It's primary goal is to assure that there are quality and effective prevention, intervention and treatment services in this country.

It serves as a focus for exchange of information between the Federal Government and the state authorities. And as an association, it provides technical assistance in the area of implementation and coordination of services.

I wish to extend, on behalf of the state authorities, our appreciation to you, Mr. Chairman, and to Members of the Committee, for the leadership that you have offered consistently. Your leadership hasn't begun and ended with the elections of 1986 in attempting to adequately address the alcohol and drug problems that exist in the United States.

For that, we thank you.

As I'm sure you are also aware, alcohol and drug issues constitute this country's number one public health problem. In 1983, alone, it was estimated that combined alcohol and drug problems cost the United States roughly $176 billion. If we could offset those figures substantially, imagine what they might do to the federal deficit.

It is estimated that last year there were 38 million adults who tried some illicit substance. One-third of our college students have been surveyed and have contended that they have used cocaine at least once.

Alcohol is the leading cause of death and disability for Americans under the age of 44. Alcohol is the third leading cause of birth defects in this country and is the one cause that is absolutely preventable.

Twenty-five percent of our AIDS victims, a disease that scares all of us in terms of its potential devestation, we find 25 percent of the cases are I.V. drug users, and 60 percent of the pediatric AIDS cases involve a parent who is an I.V. drug user.

Given those factors and the litany of problems associated with the problems that we can go over this morning, we've seen, since

1980, a drop of over 40 percent in resources (when you factor in inflation) committed to dealing with the prevention and treatment of alcohol and drug problems.

In 1986, approximately $1.3 billion was spent in the publicly-funded sector for treatment and prevention. The states contributed about 50 percent of that figure, and the Federal Government contributed less than 20 percent.

A number of questions have been asked both in solicitation for testimony before you this morning, as well as questions were asked by the Committee here this morning. And unfortunately, we cannot provide you with the comprehensive kind of response that you, Mr. Chairman, and the Committee would like.

In the implementation of the Anti-Drug Abuse Act of 1986, only some of that money has actually begun to reach the states as we speak. There have been a lot of questions regarding the distribution of money to the states, the application procedure, et cetera, and I will expand upon that shortly.

NASADAD estimates that if we, in fact, have the full allocation this fiscal year for the treatment provisions in the Anti-Drug Abuse Act, that 220,000 admissions could take place this fiscal year.

And if you talk about addressing the demand, as has been raised here this morning, something like 20 percent of the users constitute something like 80 percent of the demand. Treatment has to be an important component in an overall demand reduction strategy.

The allocations for the treatment provision were divided into two parts. Forty-five percent of the money was to be distributed via a per capita formula, and 55 percent by a need formula.

According to the Anti-Drug Abuse Act, February 27th, 1987 was to be the point in time at which these monies were to be distributed to the states. As of last week, only 26 states had received their one-quarter share of the 45 percent.

I was told this morning that 45 states now have received their first quarter payment, the 45 percent portion of the distribution of these funds. The application for the 55 percent, I understand, has gone to the governors just this week, and that the need formula, itself, is in the process of being finalized.

So when we talked about testifying before you this morning about what kinds of good things we have been able to do with this money, not having had the money, in fact, in hand to implement programs, we're not in very good shape to provide you with the kind of information that you would like about the utilization of these funds.

I'd like to speak to you briefly about the Ohio experience. We've allocated the 45 percent portion of our monies to the field. We've earmarked 50 percent of those monies for the treatment of youth.

If I were to highlight a major treatment need in this country, particularly in the State of Ohio, it would have to be in the area of serving medically indigent young people. We simply do not have a continuum of treatment services available for young people who are chemically dependent.

Half of that money that is earmarked for youth in Ohio's urban areas we have earmarked for minority youth. We recently had a report by a Minority Health Task Force in the State of Ohio that demonstrated that chemical dependency amongst both youth and adults is far more catastrophic in minority communities than it is amongst the rest of the population of the state.

So that we're hoping that with our share of these treatment dollars that we can begin to develop a continuum of service for medically indigent young people in the State of Ohio.

The governor of Ohio, Governor Richard F. Celeste, has an ongoing Council of Recovery Services that are serving as the body to coordinate all of the funds, not simply the treatment monies but also the prevention and the criminal justice dollars coming into the State of Ohio so that we, in fact, have a coordinated, comprehensive strategy and don't end up falling all over each other in attempting to implement programs with these dollars.

The state authorities for alcohol and drug abuse in Ohio will also be implementing and administering the governor's discretionary portion of the dollars flowing through the U.S. Department of Education.

In your deliberations, you may also be interested about the role that agencies, that are normally funded through ADAMHA, are also utilizing some of the other resources that have been made available by the Anti-Drug Abuse Act.

We're hoping to establish a priority for the prevention dollars aimed at children of chemically dependent parents. It's estimated, for example, that 28 million children in the United States today have an alcoholic parent.

A majority of these young people are tomorrow's chemically dependent adults. They are probably the most high risk population that we have in this country. And it seems to me that the most efficacious use of this money is to target this population.

The question was raised this morning about prison populations. We're hoping to use the 30 percent of the criminal justice portion of these monies to go to our Department of Youth Services and Rehabilitation and Corrections to begin to more appropriately address the needs of chemical dependency in those institutions.

We have surveyed our juvenile population. And our Department of Youth Services have found that 70 percent of these young people have a serious chemical dependency problem that historically has not been addressed.

Two years ago, we established four chemical dependency treatment units to begin to address that problem.

Our major concern before you this morning is the reduction of the $163 million by the Administration for treatment by 50 percent. It is our understanding that it was the language of statute and Congressional intent, in fact, that these monies be used for this current fiscal year.

There is no recommendation by the President for a new authorization level for treatment in his fiscal year 1988 budget proposal.

I can't emphasize to you enough the difficulties we have, as state directors, in attempting to implement what it is that you, as Congress, have mandated by statute. Local service providers say to me, "You want me to establish a new treatment program. You can't tell me whether or not I'm getting 100 percent of these monies or I'm actually only getting 50 percent, whether these are one-time only monies or not, and you want me to start a new service, implement it, hire a new staff, and only a year from now have to dismantle the whole operation."

It puts our local treatment programs in an untenable position and makes some of them hesitant to even take this money to implement new services if it means that in less than a year they're going to have to dismantle them.

It doesn't sound to me like a comprehensive way for us to adequately address the problems that we're talking about here this morning.

Our recommendations to you this morning are that Congress take immediate steps to communicate to the Department of Health and Human Services that the treatment monies are, indeed, a one-year allocation; that these were not intended to be monies that were distributed over the course of two years.

We urge you also to clarify and please communicate to the states that Congress intends to continue its commitment to treatment and the growth of resources to adequately address this problem for 1988 and succeeding years.

We were told, at the time that the Anti-Drug Abuse Act of 1986 was being considered, that the supplemental treatment provision was only going to be for one year because this was going to be the year that the ADMS Block Grant was up for renewal.

We strongly advocate that the ADMS Block Grant, in fact, be renewed, and that the supplemental treatment provisions be a part of that renewal process. And that we not have only a one-year authorization and allocation for treatment.

Attached to our formal testimony is a handout relative to our position as an association, relative to the ADMS Block Grant.

We propose a three-year renewal for both the block grant, itself, and the supplemental treatment provisions and advocate a 20 percent growth per year in those allocations.

We believe that that will signal the long-term commitment on the part of the Congress to adequately address these problems.

We also advocate a three-year renewal of the authorizations for the two institutes, NIAAA and NIDA. In their capacity as the major research authority for alcohol and drug problems, we advocate for more emphasis in the area of applied research.

There are many questions that we, in the field, have that need answers. There are many questions that you, as Congress, as policymakers, would like answers to. And it's difficult to have those answers if we don't have more in the way of applied research and less of an emphasis biochemical research.

We need to know outcome measures. We need to know what kinds of methodologies work best with what kinds of populations.

We applaud the creation of the Office of Substance Abuse Prevention. We note also that the President has not proposed a new 1988 budget for that office. And we recommend that there also be continuing authorizations for that office and have specific amounts also detailed in our attachment.

We also urge that there be mandated coordination with the state authorities on the criminal justice provisions and the educational initiatives. OSAP, in its application procedure for community-based prevention grants, is requiring that there, in fact, be some commentary and review by state authorities.

We urge that that occur likewise with other funds.

We would also like to advocate that there be a greater emphasis placed on epidemiological activities on the part of the National Institute on Drug Abuse.

I must applaud NIAAA in their epidemiological efforts. We are able now to have important information about the extent of alcohol problems county-by-county across the United States. You ask important questions about drug problems across this country that frequently we are not able to answer because we don't have that kind of data collection currently.

With regards to the ADM Block Grant, the states have voluntarily, for the last three years, been providing data on the utilization of those funds and what's going on in the publicly funded sector. But we really need a more broad-based approach to dealing with these problems.

That's the extent of my testimony before you this morning. And, again, I appreciate the opportunity to address you.

Thank you.

[The statement of Mr. Lindstrom appears on p. 55.]

The CHAIRMAN. Thank you.

Mr. Besteman?

TESTIMONY BY KARST J. BESTEMAN, EXECUTIVE DIRECTOR, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA

Mr. BESTEMAN. Thank you, Mr. Chairman. And I appreciate the opportunity to appear before you and the Committee, and to discuss the implementation of the 1986 initiative.

I would like to confine my remarks to that initiative in three areas.

One, I believe that the Committee and the Congress should be committed to sustaining the initiative in research. Some of the things that Mr. Lindstrom has talked about, the lack of knowledge, the lack of epidemiology, the lack of hard data that can guide communities on selecting modalities and selecting what patients go in what treatment can only be answered by service research.

The evaluation of the prevention initiative which is mandated in OSAP. All of these are classically research issues. If they're neglected, in a few years we will have spent the money we have and not have a clear question of what the impact was and who benefitted from it.

And I would urge that that research and evaluation aspect be sustained by continuing to increase the resources available to the National Institute on Drug Abuse in their research budget.

The entire budget picture of trying to spread a single year's appropriation over two years' implementation has simply stunted whatever impact this initiative set out to have.

As I recall the description of it when it passed, it was considered a partial step towards a solution. It was not considered a glorious solution to the entire problem. We've taken the step and made it a half step.

Now I say "we," the "we" happens to emanate, as I have been told by the Office of Management and Budget, that rather nebulous, faceless organization that instructs the bureaucracy how to spend money, but the fact of the matter is——

The CHAIRMAN. I don't know why people continuously do that. It's the President's budget. So let's talk about it, you know.

Mr. BESTEMAN. Okay. I'm willing to say that it's the President's budget. But the way the information flows to the Agency when you ask, "Who instructed you to do this," the Agency personnel tell you it came from the OMB. They don't tell you that it came from the President.

The CHAIRMAN. Okay.

Mr. BESTEMAN. So that's why I use that language.

The CHAIRMAN. I'm sorry. I apologize. But you're absolutely right. When we receive OMB's budget this is the President's budget.

Mr. BESTEMAN. And if this is the President's budget, then he has publicly reneged on the commitments he made in October and, I believe it was, late September that he appeared on television.

That's his privilege. That is his decision. I think it's bad public policy for the country, and I don't believe that the Congress should endorse it or allow it to happen. I think it will be damaging to the long term effort in drug abuse.

Now, as regards the problem with the implementation of the block grant, that problem comes from a classic piece of behavior which goes way back into the 1970s, if some of you can remember when the Special Action Office was formed in the Nixon Administration.

In the formula grant there, one-third of the money was to be distributed on need. I was then part of the government's staff that had to decide what would compose that element of need.

It was the most impossibly complex set of negotiations with states who wanted to have the need factors to benefit their statistics. The 50 states don't keep similar statistics.

New York keeps its statistics a certain way. Therefore it would say, "We think these data should constitute need." A perfectly logical argument.

Texas keeps another set of statistics and would say, "We believe our data should constitute need." California would have another idea, Pennsylvania another idea.

The fact of the matter, in 1972 and 1973 when we finally untangled this, is we went to indicators which basically correlated back to population.

One of the things in the reauthorization that I would urge the Congress to do is simply eliminate the "needs" formula if you want impact because the bogging down of the impact of this initiative has happened when my friends, the state directors, and others, have started pressuring the Alcohol and Drug Abuse Administration over how should you distribute this money.

One cannot get a single agreement nationally on what the need factor is. And we're looking for equity. The thing that most block grants have to go back to is population. And that's difficult to do because everyone looks at their state and says, "My state is unique," or "My city is unique."

But we've stumbled on this, and we've stumbled on it with the NARA program early on in 1966 and 1967. We stumbled on it with the formula grant in the early 1970s. And we're stumbling on it again when we have a really urgent, need to take action.

As understandable as it is, from a legitimate, parochial view, for the good of the nation, I think the need aspect of flowing money has to be set aside in the reauthorization or we're going to go through this every year as people develop new needs data: or we're going to wait for 3 to 5 years while the Federal Government has to reconstruct the data base.

And I don't think we can wait that long and squabble over it.

Now as regards the OSAP office, it, too, has a rather limited budget being spread over two years. I fear that the impact of that office, which would have been modest in any event, 20 plus million dollars, 40 at a maximum, being spread nationally may become inconsequential to spread over two years.

Again, you have programs that are going to be initiated, know that they have, at best, a two-year life span under the present set of circumstances, and fear disappearing from the face of the community. I do not believe that is the way that we ought to be going about preventing drug abuse.

We know, from every bit of data that we have in the research and evaluation arena, that we need persistent, consistent work with youngsters and adults in this society, and that it is over the course of years that our society's behavior changes.

And if you want to just take a look at one issue, just look at the difference in smoking behavior in this country. It did not occur in one or two years. It has occurred over approximately three decades.

We are dealing with a compulsive, repetitive, relapsing behavior called addiction. We are not going to change that miraculously. It's something that takes constant effort.

That constant effort has to be framed in permanence, not in peaks and valleys, not with somebody saying, "I can run in and get a grant now," but tomorrow its gone. And that is an extremely important message to get across to the professionals who are dedicated and who are working in the community trying to do a good job.

My members include local treatment organizations. I had a meeting in Florida last month and several of them were there. They are, indeed, leery at expanding their programs right now, well aware that capriciously they could put in new staff, new beds, new capacity and have to start dismantling within one year of having built it.

That is not the way to run any kind of community service. And they know it. So there's that reticence waiting to see what is the Congress going to do with the authorization and with the appropriation it is now considering.

And clearly, a strong signal has to be sent to the field that we're in this for the duration. This is not a whim. And I think that's extremely important.

The details that Mr. Lindstrom spoke of in Ohio are being repeated in several other states. I have data to that effect, reports from state directors and local treatment agencies.

But I do believe, from the statements I have heard from several members of this Committee, that there is a willingness to dig in and continue this effort. It needs to be accomplished.

Thank you very much. I'd be willing to answer any questions.

[The statement of Mr. Besteman appears on p. 65.]

The CHAIRMAN. Okay. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman. I appreciate your taking me out of order. I have to attend another hearing and I'll be right back here.

Are both of you gentlemen suggesting that we not base the distribution of funding on the needs test but go back to population?

We've had a serious review of the formula, and it's a very complex formula. And we've asked the Administration to simplify the formula and go back to the Congressional intent. But I certainly welcome your clarifying where you stand on the needs test or the population test for both.

Mr. LINDSTROM. The goal of a need formula, I think, is a noble one. And one that I think requires close examination. We, as a state, have just gone through kind of the same exercise that ADAMHA has gone through in a very brief period of time in trying to develop a need formula.

After we spent a year of looking at various variables and a combination thereof, in establishing a need formula, we found that in the end, as Karst just said, it correlated very closely to what we have with per capita distribution.

There wasn't a significant difference. I think that looking at the development of a need formula is something that is a worthwhile goal for the institutes to look at over the long run.

But to say that within a four-month timeframe from the signing of this bill to have that formula in place, and get all the states to buy in and be a part of, et cetera, is unrealistic.

Mr. GILMAN. Well, what's your alternative?

Mr. LINDSTROM. The alternative would be to go back to the same distribution that we have on the block grant as a whole, and that's a per capita distribution.

Mr. GILMAN. Are you both in agreement?

Mr. BESTEMAN. I have proposed that regularly. I proposed that over the last 15 years. And obviously I haven't been very persuasive.

Mr. GILMAN. Congress has attempted to make some accommodation in basing it 45 percent on the population and 55 percent on need. You don't agree with that?

Mr. BESTEMAN. Well, I don't agree with the outcome. The outcome has been that 55 percent is stalled and the arguments start. And that's my problem. And everytime we've introduced a new idea of need, that's happened.

It took us over 18 months to negotiate it back in the early 1970s in order to get the states on board.

Mr. GILMAN. So to avoid the time problem, you say get rid of the needs test.

Mr. BESTEMAN. Because the correlation of need is so close to population, after we go through all this data, Hepatitis to I.V. drug users, and so on, when you do the statistical analysis it comes back to the center of population and you're dealing with marginal dollars for each state.

It's not worth the effort.

Mr. LINDSTROM. I think another important thing to recognize, and I know the primary domain of this Committee is on narcotics, but states have different problems with different substances.

Ohio doesn't pretend to have the kind of problem that New York City has. And, thank God that we don't. But when you look at other kinds of problems, 60 percent of our emergency room admissions for drug overdoses are not for illicit drugs, they're for licit drugs.

Seventy percent of our deaths due to drugs are not illicit substances. They're licit substances. So we have some significant problems with a variety of substances, but they aren't necessarily the same substances that New York has a problem with.

Mr. GILMAN. Thank you. And thank you, Mr. Chairman.

The CHAIRMAN. Let me make it clear that we need all the help we can get with this legislation. We need it now so that we can prepare for the next year.

The Administration not only did not give us any assistance, but vigorously opposed any legislation in this area at all.

I assume that there's no dispute, or it's accepted knowledge in the so-called industry. The Administration truly feels that this is a local problem, a state problem, or a charitable organization, or whatever.

But it's not federal in nature. And so I, like you, was really elated when the President and the First Lady, and other people in need of national attention at pre-election time, were called to the White House to witness the signing of the bill.

Because I thought what it was was commitment. Whether the bill was good or bad, it is not that important. If the commitment is there, then the Adminstration or legislators can work together to get a better bill. That's what we hope to have.

That's why some of us were shocked and others outraged that the initial appropriation would be stretched out for a two-year period where even the least competent of people that are available to be trained and to serve certainly would not even know by the time the first year went into actuality whether they have a job the next year.

To me, this type of thinking attempts to sabotage the whole effort and the momentum that we have in the country and in the Congress. We have thought that need made a lot of sense. Obviously you professionals believe what we attempted to achieve is not worth it in terms of what we lose in time. And we're glad to hear that.

I hope that you will take a critical analysis of the bill. We will take a critical analysis of the Administration. But try to give us assistance as to what can work. And I'm so pleased that you're emphasizing research.

How in the devil 200 to 300 tons of drugs coming into these United States and poisoning our kids and our business people, and air traffic control, and nuclear plants cannot be considered a threat to our national security, I don't know.

Why we can't get the military and the State Department to treat this as a threat to our national security, I don't know. But at least it should be treated like AIDS is treated and that is give us a count on what research is done, what is working, what is not working, and to get that information out to you people in the field rather than just relying on small samples.

I don't know. Perhaps we'll get some answers today. But I just hope I can get a continuing commitment, not in supporting what we've done but in criticizing the bill for the purpose of improving the legislation, and in letting us know what else we can do.

We have a crisis in money, but we don't have a crisis in support. And the American people are really asking this Congress to do something.

We've got to keep doing it until we get it right. And we have enough people to override vetoes. So it's important that if we can't get help from the Administration, and in no area do we see that help forthcoming, then we're going to have to depend on your people to help us.

Mr. McKinney?

Mr. McKinney. Thank you, Mr. Chairman.

Sort of a non sequitur, but while we've got this state audience here, all these nice people, I would hope that you would stop at the Cannon Rotunda on your way out and look at the viewpoint of children whose parents are alcoholics.

It's sponsored by a New York citizen, wife of the Chairman of American Can, and it has been there for about two weeks. But it's an appalling view of the world from the image point of view of those who don't know how to lie to the kids.

And it gives you an idea of the educational problem we've got, whether it's Ohio, New York, Connecticut, or where.

I couldn't agree more with you on your needs formula. It's impossible to solve. And what are the needs? If you go west, in my southwestern Connecticut District, towards New York, you run into cocaine, heroin and crack.

If you go east into my suburban countryside, alcohol, alcohol, alcohol, alcohol. My daughter is a drug counselor for the Mid-Fairfield Drug Abuse Bureau, counseling at a school in Westport, Connecticut called the Staples High School.

Some of the richest and best in the world and some of the most troubled in many ways. She gets paid well. I figure she makes about—she has a child and an apartment to support, she gets $12,200 a year, it's about $2,000 a year less than you would earn now at McDonald's 40 hours a week, 52 weeks out of the year.

So I keep, in a fatherly interfering way, saying why not more money? How can you possibly take a trained drug counselor and pay them less than almost anybody you can mention? "Well, we don't know if we're going to get anymore money. We'll give them a bonus if we have anymore money."

Which comes into your whole point of the on again, off again things. These people need a—it's a constant frustration of the counselors that they want to do this. And yet, they don't know if they can do it because they don't know if the money will be there next year.

And everything from camps to peer groups, to everything else, all of it costs a certain amount of money. And they just don't know if they can do it. And it's the most amazing thing that in Connecticut which is, I believe at this point, per capita the wealthiest state in the Union, that in Fairfield County, which is probably one of the wealthiest counties in the Union, that people who are trying to serve the people of that area just don't know which end is going to be up the next month, or whether there's going to be any pay.

And there are many times, in fact, that some of these groups have had to go out and make a public solicitation of ex-alcoholics and others who are willing to do the job.

So I think that everybody has got the need. The problem is different in every area. And we'll certainly say that it's a lot worse in South Philadelphia and in Harlem than it is in Fairfield County, but it's still there. And it really ought to be done on the basis of population. I couldn't agree with you more.

Thank you.

The CHAIRMAN. Mr. Fauntroy?

Mr. FAUNTROY. Thank you, Mr. Chairman. I just want to associate myself with the remarks of Mr. McKinney with respect to the need for the population correlation. We can thank those who've done the research to date, but we don't need anymore research on the question of population correlation.

I think it's a nationwide problem and one that requires that we address it in terms of the nationwide population and concentrations. In addition to the excellent research that has gone on in the past, to establish the enormous damage done by these drugs, I think this is an important issue.

Quite frankly, I'm more concerned at this point with what we are doing in actual treatment and prevention. And for that reason, I'm interested in Mr. Besteman's account of those in treatment and in prevention who apparently know what the need is in their jurisdictions, who certainly want to expand their ability to meet that need but are afraid because they don't know what resources are going to be made available.

And in response to that question, that issue, what is the assessment of either of you of what ought to be the federal commitment to this problem of treatment and prevention, given what you know about the population concentrations and levels of need?

Mr. LINDSTROM. Should we begin with the budget or the Pentagon? [Laughter.]

Mr. FAUNTROY. Certainly, I'm sure that the people who are looking to expand their beds and their counseling capabilities have some idea of what they need on that jurisdictional basis.

And therefore, I wonder if you could expand that to what we ought to be thinking about in terms of a statement of what, in fact, is needed.

Mr. BESTEMAN. I think there are two pieces to that. One is that the expansion ought to be an orderly and incremental one. In other words, I think I could make a case very, very easily in treatment funding related, if you will, to the block grant, of another $100 or $150 million. I don't think I would have any trouble doing that.

But I would say to you come at it incrementally so that these huge amount leaps that are then out of context don't cause the worry and the concern that we're going to get zero the next year. That leaves everybody unwilling to make the commitment.

You may get more impact out of an incremental increase just to soak up the waiting list or to expand capacity by *x* percent. That's a public policy priority debate. We think it could be expanded, I think, without a great deal of problem by 10 to 25 percent.

But to do this in an orderly fashion is more important than my saying, well, if you raise the block grant to, let's say, a billion-and-a-half, that, in itself, would cause more chaos if we didn't know what was going on in the second year. If you did that kind of large jump right now, the field would have trouble with the management of it and how fast can the system expand.

There's willingness. There are people who are capable of providing the treatment. And I think the most important thing is to start to take a longer view of what are we going to do over a 3- to 5- to 10-year range.

And if, at any point in this time, there is the slightest indication that we're successful and the numbers are going down, and there will be, don't abandon the effort because we've done that before. We had the slightest inkling in the mid-'70s that we had done something with heroin, and I can quote one infamous phrase about turning somebody's corner, if you remember.

And immediately, people started backing away. Now I think we still have a horrendous heroin problem in this country because when I came in the field, we were upset that the number, by DEA's number, I think, was at the end, wasn't it?

The Federal Bureau of Narcotics was 68,000, and at that time, NIMH said there may be as many as 120,000. This was considered a serious problem.

Mr. **Dornan**. What year?

Mr. **Besteman**. 1957. And 30 years ago, that was considered a serious problem. Today we say the heroin problem is not acute because it stabilized at a half a million.

And I heard public figures say that. Now, that's like saying you stabilize with a temperature of about 103. [Laughter.]

That's nice, but you're sick, you know. And I want some long-term view of this in terms of, as a professional, trying to help the field mean something over time and make a difference.

Mr. **Lindstrom**. Mr. Chairman and Mr. Fauntroy, perhaps I can be a little more concrete in direct response to that question. We have done an assessment in the State of Ohio about what it would take in additional resources to treat the number of people who present, or potential presenters for treatment, for just alcoholism alone, to give you an illustration.

Our annual budget to treat and prevent alcohol problems in the State of Ohio was $16.8 million a year. That includes what we get in federal block grant dollars.

By comparison, the Community Mental Health Board in the City of Cleveland, Ohio has a budget in excess of $27 million, to give you a comparison of where we are in terms of attempting to deal with this problem as a state.

To attempt to treat those needing alcoholism treatment services alone on an annual basis would require an additional $41 to $42 million a year in excess of the money that we have presently.

And that isn't looking at drugs, and that's not looking at what it would take to adequately treat youth who are chemically dependent. So we're talking about substantial increases over what the resources that we have available to address the treatment needs presently.

Mr. **Fauntroy**. Thank you, Mr. Chairman.

The **Chairman**. Mr. Oxley?

Mr. **Oxley**. Thank you, Mr. Chairman.

Mr. Lindstrom, first of all, welcome. Ohio has been one of the, I think, leaders in innovative programs in the drug and alcohol arena. I appreciate your being here with us today.

You had mentioned the AIDS victims particularly that had contracted AIDS through I.V. drug use. Is your understanding that this legislation covers the treatment for someone who would have contracted AIDS in that way?

Mr. **Lindstrom**. Mr. Chairman, Mr. Oxley, I don't believe that the bill specifically addresses that. However, from our perspective, we have published guidelines for all of our drug treatment programs in the State of Ohio. If they are receiving state funds, then we expect them, in fact, to provide a resource for the treatment of the person who has AIDS and who is in need of drug treatment unless their level of care is such that it's beyond what a drug treatment program could provide.

If they're more appropriate on admission for a hospital then that's where they are today. But any expansion we would have of service as a result of the supplemental treatment provisions of this Act, and the person was an AIDS carrier whether he had active AIDS or not, we would see them admitted to our drug treatment facilities.

Mr. **Oxley**. And then you would make a determination, then, at that point as to whether they were considered to be drug dependent or need the drug treatment as opposed to having contracted AIDS, and separate that—the AIDS disease, if you will, from the drug dependency?

Mr. **Lindstrom**. Well, if they were, in fact, determined to carry the HTVL-3 virus and we did an assessment that they were drug dependent and they did not need acute medical care, then we would deem them an appropriate admission to one of our drug treatment facilities.

Mr. **Oxley**. And that is based not necessarily on need by the individual but whether, in fact, they are considered to be drug dependent?

Well, I'm saying, for example, if the individual had private insurance, for example, how would that be treated under your situation?

Mr. **Lindstrom**. If it were private insurance, then they would most likely seek treatment in a private facility. If they were medically indigent, then they probably would be admitted into the programs that are under our domain, the publicly funded sector.

Mr. **Oxley**. You had mentioned, I believe you used the statistic, 20 percent of the user is equal to 80 percent of the demand. Is that correct?

Mr. **Lindstrom**. Those are estimates. Yes.

Mr. **Oxley**. Those are national figures?

Mr. **Lindstrom**. Correct.

Mr. **Oxley**. So that basically, as in most of these kind of situations, it is a relatively small percentage of individuals who represent the large part of the demand?

Mr. LINDSTROM. Correct.

Mr. OXLEY. Okay. I thought that was an interesting statistic. In the area of need, Mr. Besteman, your quarrel, then, is really with the formula setup by the statute, not necessarily the efforts by HHS to set the guidelines or to try to have the states meet the certain need guide-lines.

Is that correct?

Mr. BESTEMAN. I am saying, as a person who has dealt with this issue, that when the statute requires a need formula, it inevitably provokes a fight among the states who then, when they don't quite get the formula they want, turn to their Congressional delegations who then, in turn, turn to the Administrative officials. And instead of us having our eye on what we're trying to do, which is treat drug abuse, we have our eye on, "Can we squeeze a few extra dollars inside of our state boundary."

And it simply diverts our efforts. And it has done it in my career about three or four times. And so I'm, at this point, saying, "Please, gentlemen, don't do that to us again."

Mr. OXLEY. Well, we already did, didn't we?

Mr. BESTEMAN. Yes, you did. [Laughter.]

But you're going to reauthorize each year and I'm saying, "Don't do it again. Please."

Mr. OXLEY. Well, we had hoped to pass that along to the appropriate legislative committee because, obviously, this is a Select Committee as opposed to a Legislative Committee.

But clearly, I think your point is well taken. There are reasons, obviously, why The Congress seeks to do these kinds of things and they've been basically unsaid this morning. But I think all of us recognize that there are some politics involved in here, there's some regionalism, and state-ism.

Mr. BESTEMAN. Even rationally, I think I can make an argument that need is a very nice concept. It's just that in frailty, we have never been able to implement it without contention.

Mr. OXLEY. I understand that and I think that that's a point that's well taken. My only point was that obviously this was not a perfect bill when we passed it. There's been some criticism, perhaps some of it justified, towards the Administration.

This clearly is a criticism that should be directed towards The Congress. And I respect your opinion on that. And I think there's clearly something that we should look at in terms of the reauthorization of this portion of the legislation.

So what you would basically provide is that instead of the 45 percent, under that part of the block grant, it would basically be 100 percent. Do you agree with that as well, Mr. Lindstrom?

Mr. LINDSTROM. I would agree with that.

Mr. OXLEY. And do you think that most of your colleagues from other states would share in your opinion on that?

Mr. LINDSTROM. I would say most.

[Laughter.]

Mr. OXLEY. Okay. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Dornan.

Mr. DORNAN. Thank you, Mr. Chairman.

Gentlemen, thank you for your testimony this morning. It's fascinating. The 30-year overview of this massive American problem is so valuable. I was talking to our Republican counsel, Elliott, asking him when this Committee was first chartered. And he said it was September of 1976 that we had our first meeting.

So we've gone a little over a decade. I've been with Mr. Brown from the cocaine fields of South America to the opium fields of the golden triangle of Southeast Asia and looked at this thing for a decade as a Congressman and for a decade preceding that as, I hope, a conscientious television host dedicating an hour or more a week in a weekly show to alcohol and various forms of narcotic abuse up to and including prescription drugs.

And I see it causing so much expense, so many problems down the road for the future of this country; so much budgetary expense.

And I'm going to ask you for an opinion that's not very scientific, in very round figures—as we say, "ballpark figures"—but it has to do with people who totally live off the work efforts of others.

And as part of a Western Judeo Christian culture, we're not only supposed to help them, we're supposed to love them.

Let me start with a quote that was very dramatic by the Cardinal of our largest metropolitan area, New York. Cardinal O'Connor went up to Albany this past week. His was the strongest lobbying I've ever seen by a religious organization, which happens to be my church.

Two thousand people rally and they go out into all the offices of the Senators and Assemblymen in New York. And the keynote speaker of their morning breakfast rally was Cardinal O'Connor, and he said: "Whether you are the governor in a beautiful mansion, or living at the exclusive address I have . . ." and he lives in that beautiful house behind St. Patrick's; he looks out on Madison Avenue at the big Helmsley Palace Hotel, he said, ". . . we can look out our windows and see homeless people huddled against the cold in the doorways of our cities."

Now, since you work alcoholism, in addition to drugs, and since the homeless problem in this country has received a lot of attention, have you ever sat down and tried to figure out what percentage of the homeless men and women—I was looking at some very young women on 17th Street just about four blocks from the White House at some of those legal buildings, recently sleeping in the Metro doorway right there just north of the White House, very young women; one must have been 27 or 28 years of age and totally sort of spaced out street people—what percentage of these people are in the street, this huge category that the Cardinal talked about called the "homeless," what percentage are there because of alcohol or drug abuse?

I know it's not because they flunked chemistry in high school. It's not because their father was mean to them, although that may be a few cases, or even beat them, abused them.

I know it's not because they didn't like their boss and got fired so they decided to turn to the streets.

What percentage would not be there if they had never touched alcohol, never touched an illegal or over-prescribed substance in their life? So you're dealing with 100 percent basically.

Mr. LINDSTROM. Mr. Chairman and Mr. Dornan, it's a very timely question. We just completed a survey about eight months ago in the State of Ohio of our homeless population to answer that question, and a number of others, regarding the homeless.

Mr. DORNAN. What triggered that study? Honestly, I can hardly wait for your answer because I didn't know you had a study for me.

Mr. LINDSTROM. I'll send you a copy of that study. I think that we've had the same concerns that you have had. And I think, given the recent recession and we can argue whether or not we're still in it, and there are a great many indicators to suggest that we are, that we found Ohio's homeless population increasing dramatically.

The services that we had in place in terms of shelter as well as food pantries were finding their shelves empty and finding people at night waiting out in the cold and in the street when the shelter doors had to be closed because they were already in excess of what fire regulations would permit.

That's really what gave us the impetus to institute the study.

We found that in excess of 50 percent of these folks had a serious alcohol and drug problem.

Mr. DORNAN. More than 50 percent.

Mr. LINDSTROM. More than 50 percent.

Mr. DORNAN. So unemployment might take care of half, but the other half goes back over their lifetime that at some point they turned to the street because of a dependency on some form of chemical.

Mr. LINDSTROM. Yes. And institutionalization is also a big part of that and we also have data related to that as well. And I will, when I get back to Ohio, forward a copy of that study to all the members of the Committee.

Mr. DORNAN. Each state would do the same kind of thing.

And the final question to Mr. Besteman.

Are we institutionally looking at a holding pattern, that is to say holding steady with respect to the drug epidemic? See, I remember the heroin figure in 1968, 1969 when I was doing this on television, it was 300,000. And then it took a slight dip. And everybody said, "It's going down."

But I don't think anybody ever said it went down more than 4 or 5 percent. Now it's steady at 500,000. Is there any area of drugs, other than LSD which I've read, with some chagrin, is making a slight comeback somewhere, is there anything other than the psychodelic fascination that has gone down?

Are we making headway anywhere? Smoking, I know we are in that one health problem. But in all this chemical dependency, where are we doing more than leveling off? Where are we penetrating the consciousness of youth where they're rejecting something?

Mr. BESTEMAN. Well, "rejecting," I don't know, may be too strong. But using less of. At least I think the way we handled quaaludes which, I might say, was probably six or eight years late because we didn't look at what happened in England.

But we did and that abuse has gone down significantly. I think the history of the abuse of barbiturates, while it's still serious in terms of life threatening in terms of the numbers, are down.

I think the abuse of amphetamines are down from various earlier epidemics. And I think the abuse of heroin could, again, be taken down if we would aggressively address it, not only domestically but we have some special problems internationally, as this Committee well knows, in the production.

But there are opportunities to do things there. But I think those are examples where we have had some success by taking a relatively long term view on how we were going to deal with certain substances.

It's our inattention that I believe is most damaging.

Mr. **Lindstrom**. Mr. Chairman and Mr. Dornan, I think if you look at the National Household Survey as well as National High School Students Survey, you find that the majority of substances, in fact, are showing a progressive decline.

The exceptions to that certainly are cocaine, particularly with the introduction of crack. Students in the State of Ohio can get a pebble of crack for $5.00 which is certainly in the price range affordable to many students.

And the other place where we see significant growth is in the pop wine market, the Bartles and Jaymes, the coolers.

And so while we find the per capita consumption rate of alcohol tending to go down, in the area of the wine coolers it's significantly increasing particularly amongst the young.

Mr. **Dornan**. Mr. Chairman, my time has expired. Would you indulge me one short question because of the frightening thing that I encountered in California.

Last week, when I was home in the district, the sister of a distinguished Democratic Senator, Max Baucus of Montana, came to see me. She's married and lives in Orange County in my district. And she had another lady with her, who was pursuing another excellent grassroots drug health program for young people.

And the younger lady told me she has only one daughter who is about 13 years of age, and that it was this young daughter's experience in high school that people were passing out cocaine free. And that stunned me.

She said down even into the grade school. And I said, "Not as a marketing device the way they used to give away cigarettes on airplanes, little packets of four or five cigarettes?"

She said, "Oh, yes. They feel that this will pay off amazingly within just a few years when they start getting some spending money in their junior and senior years. So some of that salary from that hard work at McDonalds goes to support a drug habit that started out free." Tell me you haven't run into that in Ohio, free drugs at the high school level to establish a habit?

Mr. **Lindstrom**. Mr. Chairman and Mr. Dornan, that marketing technique, as well as most of the marketing kinds of measures we find from Madison Avenue, have transcended into the illicit drug market.

This is not a naive business that marketeers are in to. They are very sophisticated. They do their own marketing analysis. When the demand is down in a particular substance, they have their own research going on on what might be the next substance to introduce.

You might look at designer drugs, for example. We haven't seen anything yet in terms of what's going to be on the streets within the next few years.

The **Chairman**. We have a time problem.

I've been advised that Dr. Macdonald from the Administration will have to leave at 11:20. So I wanted Mr. DioGuardi to be able to inquire.

But what would your time schedules be? Do you gentlemen have a time problem?

Mr. LINDSTROM. I have a flight out, Mr. Chairman, at 3:00 o'clock. Until about 2:00, I'm yours.

The CHAIRMAN. Why won't Dr. Macdonald, then, join us and I ask my colleague to yield at this time and we can hear from Dr. Donald Macdonald who is the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration.

Why don't you sit right there doctor, we welcome your testimony. We have received it, and without objection from the Committee, it would be entered into the record.

Perhaps, since your time is limited, you might feel more comfortable in making those points which you think are most important in your testimony.

And Dr. Schuster, from the National Institute on Drug Abuse, I understand, will be able to stay with us.

Thank you, doctor.

TESTIMONY BY DONALD IAN MACDONALD, M.D., ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Dr. MACDONALD. Thank you, sir. And I apologize for having to leave early.

I thought that rather than reading my statement, which you have in the interest of time I'll just answer questions if that's all right with you.

One of the things that I might say ahead of time, is that I'm really not here as the White House spokesperson. I'm here as the ADAMHA Administrator and would like to confine my remarks to ADAMHA issues, which are issues of research, issues of treatment, issues of prevention, and those questions the Congress is obviously concerned about regarding jurisdicational overlap and how we coordinate with other federal agencies.

I realize that sometimes it's hard to draw the line and I'm not throwing any gauntlet down.

But answering yours questions, I think, might be a better way to go, Mr. Rangel.

[The prepared statement of Dr. Macdonald appears on p. 71.]

The CHAIRMAN. Well, I think that enough questions have been raised—Mr. Fauntroy, I yield.

Mr. FAUNTROY. No. I'm not ready to ask any questions yet. Thank you.

The CHAIRMAN. Well, I had thought that enough questions had been raised as relates to whether it's foreseen by the Administration or your office as a national problem. And if so, whether or not, when the Congress starts talking about two and three years and then other people say that the monies have to be spread over a two-year period, and we're not going to fund you for 1988, whether or not it makes any sense when we ask people to expand their treatment and rehabilitation facilities that they have to plan just for a few months in 1987.

You know, what I really would like to know is what do you think about the bill that the Congress passed?

Dr. MACDONALD. I thought it was a very exciting bill, and continue to believe that. I'd like to respond to some of the things that you've just mentioned in those comments.

The questions of "Is this a Federal problem?" or "Is this a local problem?" I would like to address in different terms. I would say this is a "national" problem.

I think it's much more than a Federal problem. And I think the solution is much more than just a federal solution.

I would not underestimate the efforts of volunteer organizations or the tremendous change in attitude that has occurred in this country.

Maybe the biggest change we've seen, very positively, is a change by the American people about acceptance of drugs.

The CHAIRMAN. We're with you 100 percent. And we're with Nancy Reagan. We laud her efforts. And I pray every night that her troops, you know, are large.

Let's find out what you think the federal partnership or contribution should be.

Dr. MACDONALD. What we can do today is tell you how excited we are about the new budget. The new budget being the 1987, 1988 budget seen as a——

The CHAIRMAN. As part of the 1988 budget?

Dr. MACDONALD. As a part of the 1988 budget. The difference is not so much whether we're interested in drugs. We obviously all are.

The question was "Did Congress appropriate money for one year?" or did Congress, as some of the language of the law suggests, say, "Spend the money but spend it wisely and rapidly?" With the understanding that some of these things would be funded over a two-year period.

Obviously the Appropriations Committees, in the Congress will decide how they finally want this language interpreted, regarding funding levels. But, to me, it's the half empty, half full glass analogy. I'm really excited about the Office of Substance Abuse Prevention, a new office.

Dr. Bell, who sits at the end of the table, is heading that office. I can report on some of the things that we're doing with new money. Now whether $20 million of new funds is as good as $40 million, or $40 million is as good as $80 million, we can discuss. But in any event, it's a major enhancement.

What that office is doing is moving very rapidly to get money to the field. Approximately half of the $40 million, $20 million goes for looking at high risk youth, kids that don't fit the "Just Say No" formula. Kids that have, we believe, underlying difficulties, such as dysfunctional families.

I certainly appreciated the remark made earlier about the children of alcoholics, who are among those kids who have all sorts of underlying problems. Our demonstration grant announcement concerning these high risk youth has gone out. We've actually mailed it to 4,000 potential applicants.

We're looking at a clearinghouse that's going to be more responsive. We're looking at major enhancements to our community assistance programs. In research, and you may wish to question Dr. Schuster who is a researcher and Director of NIDA, the researchers would always like more money.

And I think it's marvelous that they have gotten that. When you look at the NIDA fiscal years from 1986 to 1988, what you see is a major increase in the NIDA research budget.

You can see that increase reflected in all of the major drug abuse areas. The question, I guess, really is in many ways, "What's 1989 going to look like?" With this blip, this large rise in 1987, we see an important stimulus. But if we stretch it out, we still see ourselves coming out way ahead.

For example, looking at the fiscal year 1988 numbers—just let me go back to the block grant. That's something the Administration allegedly is not in support of. However, if you take the new money for the block grants, which includes this new substance abuse increase, the so-called "55/45 money" plus the additional $13 million appropriated for the overall block grant, and instead of accounting for it all in 1987, you spread it over two years, what you end up with in 1988 is $342 million of new substance abuse grants.

And that's an increase of 30 percent over what we spent in 1981 and it's an increase of 42 percent over what we spent in 1986.

So you can cut it either way. I see that we've made a major commitment to drug use and I guess the Congress and the President have to argue if we should make a more major commitment.

I'm not disappointed with the programs that are going on in this Administration.

The CHAIRMAN. Well, I certainly have more questions but they deal with policy.

Congressman Fauntroy was trying to say something.

Mr. FAUNTROY. Mr. Chairman, I would like to be taken out of order because I have a commitment.

But I was looking forward to Dr. Macdonald's testimony. And I just hope that he has not placed off limits any questions relating to his role as the special narcotics advisor to the President.

How long have you been in that capacity?

Dr. MACDONALD. I've been there about three or four weeks.

Mr. FAUNTROY. Oh, three or four weeks. Have you met with the President?

Dr. MACDONALD. Yes, sir.

Mr. FAUNTROY. And what has been your advice to him?

Dr. MACDONALD. I didn't really have any extensive discussion. I spent much more time with the First Lady one-on-one, and with former Senator Baker. I think that the President's push now would be to say, "We put up, in August, a major new initiative with six goals."

And as I see my role in the White House, it's to work on implementation of those goals. The White House Conference, which we can discuss or not discuss if you would like today, I see is a leg of implementing a plan that's up and running.

Mr. GILMAN. Will the gentleman yield?

Mr. FAUNTROY. I'd be happy to yield.

Mr. **Gilman**. While you're on it, what are the plans in the White House Conference?

Dr. **Macdonald**. I knew you would ask that, Mr. Gilman. [Laughter.]

We see the White House Conference, as obviously do Mr. Rangel and you, as a major contribution. Many of the questions that I've heard discussed previously by Karst Besteman and others are "Do we want to look again at where we are and where we need to be going?"

The Conference is seen as doing that. Officially, the Conference now has an office space. We're now hiring people. We're now organizing task forces. The President has not yet signed the Executive Order setting it up, but did sign a memorandum that made me the interim director so we can get on with business.

We are anticipating a conference of 50 to 75 people, many of whom are prescribed by law, of strong, bipartisan, high level people who will make a statement as the Conference evolves that we will see as the nation's agenda and the nation's program.

Mr. **Gilman**. When do you anticipate holding the Conference?

Dr. **Macdonald**. Well, we were hoping to hold it in late summer. I was advised this morning, by the Attorney General, that you don't get these kind of people in August. So we may be talking September. But we're talking fairly rapidly in terms of——

Mr. **Gilman**. Would you keep our Committee apprised of your plans?

Dr. **Macdonald**. Oh, absolutely.

Mr. **Gilman**. Thank you, gentlemen, for yielding.

Mr. **Fauntroy**. Okay. And I won't take much more time because I think you've begun to answer some of the questions I had.

I take it you think the Federal Government is doing enough and that what the Administration proposed is what we ought to be doing.

Dr. **Macdonald**. I don't know that it's "enough" since "enough" is defined in a lot of different ways. And as those of you who know me know I've been an anti-drug abuse zealot for the last five or six years.

Mr. **Fauntroy**. Well, I'm speaking about prevention.

Dr. **Macdonald**. I really like what the President says. The title of this Conference is "A Drug Free America." I think that's what we need to work for.

But what we have to look at in budgeting is not just deficit and balance within a larger framework, but "How ready is the system to accept new infusions of money?"

"Are we putting money into place and, in a sense, eliminating other things that don't cost money?" The Department of Education piece, in many ways, places responsibility on parents and community.

In other words, we're suggesting that's something we often neglect if we put too much money in the federal and state systems.

Mr. **Fauntroy**. I would hope that, Mr. Chairman, we do get some parity on the role as advisor as you move through the questioning period.

The **Chairman**. Thank you.

I wish we had more time, doctor, but you're going to have to just share with me what type of legislative thinking was the Administration talking about when they took our bill and decided that only one-half of it was supposed to be used for new initiatives and the other half was going to be used for the second year.

You know, I hope this is OMB type of non-dollars and cents thinking. But in terms of programs, I hope you would agree with me and the people and your colleagues sitting at the table that this is no way to be providing services.

We have put new initiatives because we wanted to make certain that the local and state people and the community people came up with new and exciting programs. And that we would monitor it.

But just to arbitrarily say 50 percent for new programs, what was the thinking? Did he share it with you?

Dr. MACDONALD. The thinking comes in several parts. You know, there is money that was put into the $1.7 billion enhancement that's obviously one-time money. Something like $325 million and that goes for AWACS and balloons, and things of that type that were a one-time capital expense.

And there would be no reason to see that double the original request for those items.

Part of the other concern is how ready the system is to handle large new sums of money. Is Dr. Schuster going to be able to award enough high quality grants? His budget, as you know, was $65 million for research.

In 1987, as many members of Congress would read it, he has a $130 million budget. That would be a doubling of the NIDA research budget without a system that has proven ready to handle it.

The CHAIRMAN. We're talking about local and state people because we're talking about these treatment centers and the staffs.

Dr. MACDONALD. Okay. In each of these things, I think you have to separate the pieces out and say, "Which piece are you talking about?" You know, the research piece is obviously different from the capital expense piece.

The treatment pieces——

The CHAIRMAN. You don't handle the AWACS, do you?

Dr. MACDONALD. Well, no. I don't have——

The CHAIRMAN. I'm talking about these people are out there and we sent the signal that they should expand and get on the ball and get these people off the street, and get them in treatment, and get them as fast as we can get the money.

Dr. MACDONALD. Let me give you some treatment numbers to go on. The concern of the Administration, in funding treatment, is that we're always a little leery to fund treatment, questioning whether that is a Federal responsibility to fund treatment.

The reason that the Administration's bill had $100 million for treatment is that we were very concerned about the waiting lists in your city and the relationship to AIDS, which is a very serious and related problem.

And we said, "We need to do something to take care of the waiting lists." Now, Mr. Gustafson from your state testified with me a month ago about how many people are on waiting lists in New York.

And, you know, those numbers are soft. We're not sure if people are on two waiting lists or if they're in detox.

But assuming that the reported numbers are correct, and a thousand people in New York are now waiting for treatment, how much does it cost to treat those people? Well, his numbers are that it would cost $3,500 a year to treat each of those people.

Those are pretty much the same numbers that NIDA gives me. That's $3.5 million in treatment money to take care of New York's waiting list problems. How much money does New York actually get? Approximately $7.2 million, more than double that.

In other words, the two-year funding for that waiting list is taken care of. At the same meeting, a gentleman from Florida, John Dingle, testified and said they had 500 people on waiting lists. Well, that's half as much as New York, and they're getting more than enough money to fund their waiting lists for two years.

The CHAIRMAN. What did you mean about there's some problem as to whether or not the Federal Government should be involved in the area of treatment?

Dr. MACDONALD. Well, I think that the question of treatment always is does the state have a contribution to make? Does private insurance have a contribution to make? Do people, themselves, have a contribution to make?

The CHAIRMAN. When the President signed the bill, was not a policy statement made as well as a legislative statement?

Dr. MACDONALD. Well, what I'm saying is that, indeed, he signed a bill which provided for treatment. And, indeed, in the President's package, he asked for treatment money. He asked for it much as you want it, to be targeted at some critical needs.

The CHAIRMAN. Well, how did you reach the 50 percent limitation on the new initiatives? Was that done in your shop or was it done in Mr. Miller's shop?

Dr. MACDONALD. Well, I think that you're correct in saying that what we present is the President's budget. And it's a budget that we all fight and argue and——

The CHAIRMAN. Well, Doctor, what I'm saying is that, you know, for people like you it's rough. You're a professional. You've made a commitment. You've taken all kinds of votes that go beyond the president.

And when we start talking about treating people and what's the best way to do it, I recognize that you're under a severe political handicap when OMB tells you that, "We don't care what the Congress has decided. We've got to cut the money. We're not going to put the money out there."

And, of course, you're restricted. But at what point do we find out how would you want to do the job? Because the Congress is going to do the job. We may just not do it right. We can do it a heck of a lot better if we had your input as to what you would want done.

But we're going to do it whether we use needs test, population test, color test, you know, whatever test. We do the best we can. We put in the needs test, not these gentlemen. Now we understand we may have been wrong. Maybe you knew we were wrong in the beginning.

But stop us from being wrong. You have the same commitment that we do. I don't have any problem with that. But how do we get support from the Administration while we're legislating?

Notwithstanding OMB, you know we're going to put the money in the budget. You know it's going to be veto-proof, you know the President is not supporting Miller's budget. You know the Congress is going to right a budget.

Mr. Miller said, "Let us see what you come up with." So that's an invitation to the Administration to help us to come up with something.

Didn't he say that, Mr. Dornan?

Mr. DORNAN. He sure did.

The CHAIRMAN. He said, "This is our budget," you know. "Now let's see your budget." So help us to have a budget that makes sense more than just political sense.

Mr. Gilman?

Mr. GILMAN. Thank you.

Doctor, there's been some discussion here this morning by the gentleman representing the state agencies that we ought to get rid of the need formula and go just on a per capita basis because it's too complex, we spend too much time working over the figures and the money doesn't get out to people.

We, in our last discussion with you, raised some objections to the change of method from what the Congress intended from a formula 45 percent need and 55 percent population. There were some revisions made by your office.

Can you tell us where we stand now on the distribution of the funds and under what formula do you intend to work with it? What are your thoughts about what the gentleman from the state agencies are saying?

Dr. MACDONALD. On, the first question, where we stand is that last week we sent to all the states the forms necessary for them to apply. And they can have those applications in today or tomorrow, or at anytime. And we intend to get the money to them.

Mr. GILMAN. On what formula?

Dr. MACDONALD. One of the limiting things was devising an application form that everybody agreed gathered the sort of data we needed to have.

The second was how to split the 55 percent. As you know, we had four factors that we used in the formula originally. And a number of people, particularly the New York delegation, objected to one of those factors. And, as I've previously communicated, we have eliminated that inverse funding factor and narrowed it down to three factors.

We are in final clearance. Most responses we got—and we got responses from 31 states—were very favorable with little change. There are still some objections that we're in the final process of clearing within the Department. But it shouldn't be long.

But the one that New York objected to most is gone.

The statement that Karst makes is a good one. I think that he realizes what we realized all of a sudden, that is, Congressional intent was very much like the Administration's intent, which was to fund those areas where there was a particularly serious problem related to waiting lists, serious drug abuse, and an AIDS relationship such as in New York.

Unfortunately, other people choose to define it differently. You know, alcohol as a factor was included in the law. And, indeed, alcohol is a major problem. Other people would say, "Well, we need to spend more money treating adolescents who smoke marijuana." And they make a good point.

So it's very, very difficult for us to arrive at a formula everyone will agree to. And in truth, what we end up with is very much like Mr. Besteman says, and that is something which approximates a population-based formula. So, you know, I don't know how to resolve that unless you specifically in law say, "We want this for opiate addiction."

We have to interpret the bill the way you write it and that's what we did.

Mr. **Gilman**. The population-based formula, is that——

Dr. **Macdonald**. No, no. We're moving towards implementing the law the way it is and, in truth, the way it works out pretty closely tracks what you would get on a population base.

Mr. **Gilman**. But still on a 45/55?

Dr. **Macdonald**. It's still a 45/55, yes. That's in the law and, indeed, the way we'll do it.

Mr. **Gilman**. One other question. I know my colleagues all want to ask you——

The **Chairman**. No. That's not the problem. The problem is Dr. Macdonald has to leave. And I did want——

Dr. **Macdonald**. I can stay for five more minutes.

Mr. **Gilman**. There's just one more question, Mr. Chairman.

The state people are telling us that the dollars haven't trickled down yet on rehabilitation. And you're telling us——

Dr. **Macdonald**. No. We have made 45 awards on the 45 percent portion of the formula. That's already gone out. And I don't want to say it's in the mail. But it has been in the mail for over a month for some states.

Mr. **Gilman**. Into the states.

Dr. **Macdonald**. Into the states.

Mr. **Gilman**. And now the states have to distribute it themselves.

Dr. **Macdonald**. Yes. And how they do it, will be different. We understand that many states may not do anything with that until their fiscal year begins.

Mr. **Gilman**. When did those checks go in the mail, Doctor?

Dr. **Macdonald**. I don't know the exact answer. Jim, when did the first one go? For some it's been over a month now.

Mr. **Gilman**. Well, is that Mr. Lindstrom and Mr.——

Dr. **Macdonald**. And they're going all the time.

Mr. **Gilman**. Has any money trickled down to any of your agencies yet?

Mr. **Lindstrom**. Mr. Chairman and Mr. Gilman, Ohio has received its 45 percent share for its first quarter payment.

Mr. **Gilman**. Has any of that been distributed in Ohio?

Mr. **Lindstrom**. We have allocated it. Not distributed it.

Mr. **Gilman**. Mr. Besteman?

Mr. **Besteman**. Well, the reports from other states are essentially the same thing. And some states, as of Monday, got calls that the state said it had not come. And other states are saying that second layer distribution has not been made.

I've heard of no operating programs that have received their distribution although they may have. But nobody has reported that.

Mr. GILMAN. Do you anticipate all of the funds will be out in the near future?

Dr. MACDONALD. Well, five states have not even applied for their 45 percent. We obviously can't distribute those until they fill in the application and write for it.

The 55 percent, again, will depend on the speed with which they respond and sign off on three or four items that they're asked to sign off on. If they were to get those to us today, which is possible, within a couple of weeks they ought to have their money.

Mr. GILMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. DioGuardi.

Mr. DIOGUARDI. Thank you, Mr. Chairman. I want to again commend you and Mr. Gilman for these investigative hearings. I think they're very important.

I was at another hearing so I couldn't make an opening statement. And I'd like to offer it for the record.

The CHAIRMAN. Without objection.

Mr. DIOGUARDI. Along with a copy of a letter I had sent to Dr. Macdonald sometime ago voicing my displeasure at the means test. I've joined the dissent of Mr. D'Amato and Mr. Moynihan on that.

[The statement of Mr. DioGuardi appears on p. 83.]

Mr. DIOGUARDI. I think New York State has a very special problem. You indicated that you eliminated one of the four factors. Which one was that?

Dr. MACDONALD. That was the one that talked about state funding as an inverse determinant. And I discussed that with a number of people, including Mr. Rangel and Mr. Gilman. And we all agreed that that was something that had to go.

Mr. DIOGUARDI. Allow me, Mr. Chairman, to repeat what I'm sure you've already said, that New York State has a very special problem, I guess, of where it is. The treatment lines are overflowing. I have a special interest in this because of my many years on the board of the Phoenix House, I have certainly seen first-hand the terrible tragedies of drug abuse to people.

Many times, we find it difficult to relate to that just in talking academically about it. But when you see first-hand what it does to one person, to one family, it really comes home as to how tragic this is and why we need to get the money flowing as soon as possible and under the right basis depending upon what area we're talking about.

So I would urge you, once again as I did in my letter, to consider the best application for our area in that 55 percent means test. New York is a desperate area and we need every dollar we can get as soon as possible.

From your comments, I assume that no allocations have been made yet under the 55 percent formula to any state?

Dr. MACDONALD. No allocations of the 55 percent formula money have been made. I think we've done very well in getting it along this far this quickly. We did, at the request of the New York delegation, slow the process. Not very much. But part of the delay was the concern that you and other members expressed about the formula as it appeared in January.

Mr. DioGuardi. Has New York State received its check under the 45 percent?

Dr. Macdonald. I'm——

Mr. Kaple. Yes.

Mr. DioGuardi. When was that done?

Mr. Kaple. I don't have that date with me.

Dr. Macdonald. They should have that money.

The Chairman. I'm surprised Senator D'Amato didn't announce it.

Mr. DioGuardi. That's right. I'd like to know when that was done. [Laughter.]

Dr. Macdonald. Apparently, it's an electronic transfer. Forget what I said about lost in the mail. It has gone.

Mr. DioGuardi. All right. It's important to us to track it to be sure that it is not held up in some other accounts in Albany and that it gets to where it's supposed to be.

But I'm very concerned that New York is not getting the specific consideration it needs because of where it is. That is, New York City is currently the capital of crack in the country and perhaps the world. So it's kind of a hub for this activity.

The treatment centers just cannot deal with the problem at this point. And obviously, if we're going to have a real war on drugs, we've got to deal with it at all levels and the money is needed as soon as possible.

I would urge you to do whatever you can to address the intent of Congress so that states like New York, with desperate problems, can get its fair share of this and get it right away.

Dr. Macdonald. I have no argument there.

The Chairman. Doctor, I know you have to leave. Do you have a legislative person in your shop that can work with these people that represent the national associations that deliver these services so that even if they cannot be accommodated, that we could get some better answers from those people who are in the field?

You see, we don't have any federal programs. We don't have anything to tell them. We can't give them any assistance. We don't have any data bank. You know. All we can do is say that the Congress has pumped out some money. That's all we can tell them.

They really want more than that. And you're not in the position to give it because we have—we are just starting in this area. Now it would be tragic if you started doing something that they don't need. And if you're not doing something that they would want you to do.

They have the—a network that they can reach out, throughout the country, and ask questions as to what is needed. Can we provide all the things they would be asking? No.

But it could very well be that what they're asking is just a central information bank to be of assistance to them.

Could you suggest to them who they might contact so that we don't go from hearing to hearing?

Dr. Macdonald. The answer is, of course, that we will provide that kind of technical assistance to you, to members of the Committee, anybody you suggest. Our legislative person is Lee Cummings who sits back here. But you might——

The CHAIRMAN. Mr. Cummings, do you people know each other?

Mr. CUMMINGS. Yes.

The CHAIRMAN. Good. Well, maybe after you get together——

Dr. MACDONALD. Yes. You know, through Bob Trachtenberg, we can meet with anybody almost anywhere at anytime.

The CHAIRMAN. Okay.

Mr. LINDSTROM. And, Mr. Chairman, I just might add, given the content of that question, that Dr. Macdonald and ADAMHA as a whole has been very cooperative and has gone well beyond the call of duty in working with the states in a variety of realms, not only around this issue.

And he's to be applauded for that.

The CHAIRMAN. Well, if you two can stop applauding each other and give us a diagram that more effective legislation can be drafted on, then you would not be coming here complaining that we didn't do it right, you know.

If you two were talking so well, why didn't we hear more about this from the Administration in terms of your complaints or in terms of the research that you want. So let's take advantage of this period of goodwill and share it with your legislators so that we can be a full team.

Dr. MACDONALD. I want to thank you too, Mr. Rangel.

The CHAIRMAN. Thank you, Doctor, and good luck to you. If you see the President, I have a list of questions too. But that's between me and you. [Laughter.]

Dr. Schuster, is there anything that you would like to add to the President's advisor's testimony?

Dr. SCHUSTER. Dr. Macdonald, in his ADAMHA capacity, stated the fact that researchers always want more money. I can only say that the research field has responded overwhelmingly to these new initiatives.

We have received hundreds, if not thousands, of telephone calls from people who have not previously been in the field of drug abuse research but have been in related areas.

They've recognized the problem. They've seen that we got increased funding, and they're responding appropriately. So we really think that we're going to have some major new players in research in the area of drug abuse than we have had in the past.

That's always a welcome sign because it brings in fresh ideas, new ideas and I'm very excited about it.

The CHAIRMAN. Well, I hope that his remark, you know, doesn't indicate anything about the Administration's attitude, it just seem as though research is such an important thing that you don't have any problem with the support that you're getting, I hope.

Dr. SCHUSTER. What I would say to that, sir, is that as Dr. Macdonald stated, one of the problems that we have is that we need a field to absorb these research dollars. We need training. We need trained researchers. And unfortunately, the field has been allowed to dwindle in terms of trained researchers.

So that it is sometimes difficult, even with major infusions of money, to have the capacity in place to utilize new funds wisely. I think we're developing that capacity and I think we're doing this in the best fashion possible.

The CHAIRMAN. Well, how can you attract researchers if the Administration is stretching out the first-year funds, not for your shop. But if the whole idea that this is just a one shot deal, doesn't that impede your ability to attract qualified people?

Dr. SCHUSTER. Of course. I think that the assumption that most of us make is one of optimism, and that is that in the 1989 budget, continuation funds would be provided to continue the research that has been initiated during the period of 1987 and 1988.

The CHAIRMAN. Well, who can we get from the Administration, without personalizing, that could get help us to draft some type of statement that would indicate that the President signing the bill was a long term commitment and not just something that was pre-election?

You know, in your field, you cannot afford to have people even to perceive that this was just done for '87 and will live until '88. And then it falls off a cliff.

Mr. TRACHTENBERG. Mr. Chairman, I'm Bob Trachtenberg, Deputy Administrator of ADAMHA.

The CHAIRMAN. Oh, I'm sorry.

Mr. TRACHTENBERG. I'm pleased to sit in for Dr. Macdonald.

I just wanted to say that with respect to the drug abuse research dollars, we never like to see peaks and valleys in research because it does send the wrong signal to the research community.

But the fact is that NIDA right now, from 1986 through 1987 and 1988, is receiving a nice increase. I think the telling issue, really, is going to be what's going to happen in 1989. We like to look at what the total number of grants are that we can support in a particular fiscal year.

The CHAIRMAN. I think NIDA is in pretty good shape. I'm just saying could I get NIDA just to make some type of statement as to what you think your needs are in the future. I mean, if we just decided that you've done enough research in 1987, you know, we gave you a chance and you didn't come up with a solution so we're going to try something different, obviously we would hear a lot of justified complaints.

But if we could hear now a statement that what NIDA intends to do, I'm certain it will go beyond 1988. And we need that type of commitment because in other areas in law enforcement, in treatment, we really don't have any statement at all from the Administration as to whether or not they're just swallowing this bill as much as they can and ignoring other parts of it by stretching out the period.

So I don't think that's asking for too much to say that the drug problem is going to be with us for awhile. To find the answers, we're going to have to make a commitment and that you are starting.

Mr. TRACHTENBERG. ADAMHA currently funds 1,600 total grants. That's the highest number of grants that ADAMHA, as an agency, has ever funded. I think the significance for us is as where we go—which includes what the 1988 level will be, it should be just about 1,600.

The question is whether we can sustain that high level of commitment in the out years, 1989 and beyond. If we can, I think that is a clear message. That's the way we look at the research opportunities.

Now the other side of it is, as you know, are really good researchers going to come in? We think they are. Are there scientific opportunities there that are exciting? Much of the explosion in terms of understanding the neuroscience of the brain came from NIDA research in the early 1970s and has opened up a whole new field of research to the biomedical field.

The CHAIRMAN. And then what happened?

Mr. TRACHTENBERG. It slipped down, but other areas have taken it over. But that research is still there. And I think now is a major opportunity for that research program.

The CHAIRMAN. I agree with you. I just hope we can get some vocal support.

Dr. Bell, welcome to the Nation's Capital. And we know you are anxious to make a major contribution to resolving this problem.

Dr. BELL. Thank you, Mr. Chairman. I certainly am committed to that and to the Committee's efforts here to legislate and to help me help those who really address the problem of prevention of drugs. That's my mission in terms of this special new office.

I appreciate that legislative oversight on the focus of prevention is very needed. We are looking forward to the implementation of this program. We've been through the developmental phase over the past three to four months with a lot of consultation with the field.

The grant announcement has gone out. We think it's going to be exceptionally well received and it's needed. We're very excited about our contract activities and we're moving along as rapidly as we can in trying to reach those community programs that are just starting, and those who wish to amplify their efforts.

I'd like to say that we're seeking major support from the private sector to amplify what resources we have. Through the Office of the Director, we have people assigned to a private sector initiative and to corporate efforts and to foundation efforts.

We also have tried very zealously to coordinate our efforts with the other governmental agencies and their efforts so that we can make sure that we're not overlapping.

I think a really exciting advent is our newly expanded clearinghouse function. The contract is to be let by May in which there will be a well defined consolidation. We will be able to reach communities out there who are seeking to invest——

The CHAIRMAN. How do you intend to reach them? Through conferences, or mail?

Mr. TRACHTENBERG. In many ways. There will be workshops, conferences, training efforts in coordination, say, with the Department of Education. We'll be reaching them by publications, public service announcement, the media.

But mostly, we're trying to reach them through the already existing parent and youth groups that are present in the communities. We're trying to identify the field which already exists and is actively promoting efforts at the community level.

The Chairman. Well, let the Congress help you. If you can share with us your outreach program so that we can put it in our newsletters that go into our districts and to say what your office and others are trying to do, and not only educate people as to what resources are out there but it does give us additional support.

So that if it works, we can continue in that effort. So let's try to do that. And I promised Dr. Macdonald that the Committee will be asking for informal meetings without the mikes, and the tables, and the podiums where we can bring the people in the field together with the people in the Administration and find out what we can do in working together without having the shadow of OMB over us.

Mr. Gilman?

Mr. Gilman. I yield to Mr. Dornan who hasn't had an opportunity to question yet.

Mr. Dornan. No, I did earlier. Go ahead.

Mr. Gilman. Okay. Mr. Trachtenberg, will some of the treatment people and rehabilitation people have an input in the White House Conference?

Mr. Trachtenberg. You're asking a question in an area in which I have very little expertise. The White House Conference is, in fact, being carried out by the White House. I'm representing ADAMHA. And I really don't know very much about the——

Mr. Gilman. Were you consulted at all?

Mr. Trachtenberg. I've been relying on Dr. Macdonald because of the fact that he's wearing two hats.

Mr. Gilman. Well, let me recommend or suggest to you that in putting together the Conference that you make certain some treatment people are included and get some expertise from around the country so that we make certain we're not overlooking that important aspect.

The Chairman. Didn't we have that in the bill? In the White House Conference, didn't we require in the bill that all areas be invited, treatment, law enforcement? It's in the bill.

But, again, we hope that you aggressively make certain that no conference can be had without your input and without the treatment people, prevention.

Mr. Gilman. Thank you, Mr. Chairman.

I'd like to ask you about this new office for substance abuse prevention. We note that in the new office, NIDA will be folded in, to some extent, as part of the clearinghouse in OSAP.

And I have here a memo saying:

> Administer the new clearinghouse for drug and alcohol abuse information mandated by the new Anti-Drug Abuse Act. And the Clearinghouse combines and expands a separate drug and alcohol clearinghouse previously maintained by NIDA, NIAAA, respectively.
>
> A new clearinghouse will disseminate information. . . .

Well, my question is, what's left for NIDA and NIAAA after this clearinghouse is established? Will there be a need for those agencies or will they now be folded into OSAP?

Can you tell us a little more?

Mr. Trachtenberg. Absolutely. I think one of the hallmarks of the legislation was to clarify the role of ADAMHA both as a research agency and as an agency that's focusing, in many respects, the same way the CDC does on the epidemiology and the other aspects of prevention of a particular problem.

I look at OSAP as being the prevention focus that doesn't deal with research, per se, but builds on the research activity that the two institutes have developed.

So what we have now are three institutes, namely—in this case, we're just talking about drugs and alcohol that will focus on the research information. They will pass on, through their research branch and their intramural activities, an understanding of what works.

That information, then, will feed into OSAP for the OSAP programs. Now, in many respects, many of the materials which may be developed, in terms of our understanding of the state of the art of a particular issue, for instance, crack, or whatever the next drug of abuse may be, will emanate, for the most part, from the national institutes. These research developments will then feed into OSAP which will then disseminate them through its clearinghouse.

So I think for the first time, what this legislation has done, has really clarified the roles of prevention and research. And I'm looking forward to some good results from this.

Mr. GILMAN. Will there be much left, though, for NIDA and NIAAA?

Mr. TRACHTENBERG. A tremendous amount. Because they will be the national research institute for alcoholism and alcohol——

Mr. GILMAN. So OSAP will be merely an informational clearinghouse?

Mr. TRACHTENBERG. No. It will be more than that because that's only one piece of their responsibility, the clearinghouse activity. In fact, through the legislation, another part will be doing the clearinghouse work for the Department of Education.

Someday I'd like to see it be the clearinghouse for the entire Federal Government in the area of drug and alcohol areas. But in addition——

Mr. GILMAN. Wasn't that what OSAP was intended to be?

Mr. TRACHTENBERG. Well, that's fairly clear in some areas. It's less clear on the other federal program areas.

Mr. GILMAN. What other areas?

Mr. TRACHTENBERG. Well, for instance, the materials that the Department of Justice, at DEA, or the Office of Juvenile Justice may put out.

Some of the areas of ACTION, for instance.

Mr. GILMAN. You mean, they won't come through that OSAP office?

Mr. TRACHTENBERG. It's not written precisely in that respect at this point. But we're talking to them about that.

Mr. GILMAN. Now, I would hope that you could work that out so you at least had one central clearinghouse where everyone can go and reach out for information. I think that would certainly be more effective.

Mr. TRACHTENBERG. Mr. Gilman, I want to challenge one word that you used, that OSAP is merely a clearinghouse because it's going to be more than that. They're going to have a non-research prevention and responsibility, such as the $20 million of grants that they will be carrying out in terms of high-risk youth.

There will also be $4 million for service demonstration activities for young people who are using gateway drugs and we're trying to develop early intervention programs for them.

The contracts are for working with communities, minority populations, parents, youth. So that the OSAP function, in terms of services—prevention service activities, will be very extensive in my view.

Mr. GILMAN. How far along are we on the demonstration project?

Mr. TRACHTENBERG. We've moved out smartly, in my opinion. We have issued the grant announcement for both the high risk demonstration, which is $20 million, plus the early intervention activities which is $4 million. Those announcements are on the street now and we're hoping for applications to be coming in very soon.

Mr. GILMAN. That money is already on its way into the states?

Mr. TRACHTENBERG. No. Those funds do not necessarily go to the states. They go to individual applicants. Of course a state could apply. But it also could be a private nonprofit organization. It could be a public organization coming in for funds to test out a particular hypothesis, a particular method of dealing with the high risk populations that were listed in the legislation.

Mr. GILMAN. How small amount will these demonstration projects go down to? It's not mostly for large projects, are they?

Mr. TRACHTENBERG. There will be some large projects where we're going to try to approach this in a systems-wide community based approach.

Mr. GILMAN. Will there be money available for small community programs?

Mr. TRACHTENBERG. Yes. There will be two parts, one for small targeted activities and one for larger community-wide systems activities.

Mr. GILMAN. I haven't seen much information about your demonstration program.

Mr. TRACHTENBERG. I'd love to give you a copy of the announcement. Before we leave today, I'll be happy to give it to you.

Mr. GILMAN. How are you disseminating that information?

Mr. TRACHTENBERG. That's what Dr. Macdonald referenced before. Is it 3 or 4,000——

Dr. BELL. We have already mailed over 4,000 copies. We are now trying to identify additional people who would benefit from receiving the announcement.

Mr. GILMAN. It's being mailed out to whom?

Dr. BELL. People that we've identified who may have an interest in developing community-based grant programs, particularly for the high-risk youth.

Dr. GILMAN. Is there some time limit on getting these proposals in?

Dr. BELL. May 15th.

Dr. GILMAN. May 15th.

Mr. TRACHTENBERG. Is that right?

Dr. BELL. Yes.

Mr. GILMAN. And information is going out to each of the states?

Dr. BELL. To all the state organizations, national organizations, and local organizations that we can identify. Over 4,000 have been directly mailed to potential applicants. And we're still looking for others.

Mr. GILMAN. Mr. Lindstrom and Mr. Besteman, have you been provided with that information?

Mr. BESTEMAN. Their mailing key hit me about three times within two days for my association. I might also say that the trade papers have summarized that announcement and it's in the trade papers, at least three different ones that I know of right now.

If somebody doesn't know that this announcement is out and they're in the field of drug or alcohol prevention, they don't subscribe to the trade paper and they don't communicate with their state or city agencies.

Mr. GILMAN. You feel, then, that it's being properly disseminated and getting out to the important people?

Mr. BESTEMAN. Yes. I think the dissemination has been good.

Mr. LINDSTROM. Mr. Gilman, we have received the announcement in Ohio. It has also gone to the National Prevention Network.

And as a state, we've distributed to our network of 125 prevention professionals around the state.

Mr. GILMAN. Thank you.

The gentleman from California.

Mr. DORNAN. Dr. Schuster and Mr. Trachtenberg and Mr. Bell, I wonder if you could comment on an earlier question I asked the distinguished bearded sages from the heartlands of middle America about this marketing technique of giving free drugs to kids.

I've been sitting here thinking about it. Stu McKinney, when he was here, from Connecticut, leaned over to me and said, "Oh, this is quite common in Connecticut even crack is being given away free to younger kids to get them interested in it."

Is Nancy Reagan aware of this marketing technique, I wonder? Or are you gentlemen aware of it?

We'll start with Dr. Schuster.

Dr. SCHUSTER. Yes, sir. I am aware of the marketing technique. I'm also aware of the fact that one of the reasons why crack has assumed such a major problem in our country is because of the marketing. When it is sold, it is sold in small enough units so that if you can afford a record album, you can afford to buy a hit of crack.

And I think this is why we have seen it take off so explosively amongst sheltered children because of this marketing procedure. I would hasten to say, it is cocaine we're talking about.

It's just a specific marketed form of cocaine. So it has all the dangers of cocaine but it's the marketing that makes it possible and available to younger children.

Mr. DORNAN. Did you see the article Mr. Gilman was telling me about in the magazine section of the New York Times over the weekend about the cocaine billionaires?

Dr. SCHUSTER. No, I did not, sir.

Mr. DORNAN. Have you seen it, Mr. Trachtenberg?

Mr. TRACHTENBERG. No, I have not.

Mr. DORNAN. I haven't seen it either. Ben's office is going to send it over to me.

When you are a billionaire you can afford clever marketing techniques in addition to building fortresses and having your own private armies which we thought was the style only in the golden triangle or in the hills of Turkey and Afghanistan.

Mr. Bell, were you aware of this marketing technique?

Dr. **Bell**. One of the reasons I am involved in this and committed to the effort is the very idea that young people, because they have young brains, are much more vulnerable to the addiction process.

That is a great market for these people who would use them to make money.

Mr. **Dornan**. You just taught me something medically. You mean a 13-year-old, because the brain cells are growing, can get addicted more quickly than an adult fully grown nervous system?

Dr. **Bell**. Relatively more susceptible to the addiction process, the earlier the age of onset of use.

Mr. **Dornan**. All right. Could I get a prenatal poll here? Do you have any children, Mr. Bell?

Dr. **Bell**. I have six and 12 grandchildren.

Mr. **Dornan**. How about our sages? How many?

Mr. **Besteman**. Two and three steps.

Mr. **Dornan**. Two and three.

Mr. **Lindstrom**. This sage has six.

Mr. **Dornan**. Wait a minute. What do I hear? I hear that from high forheaded bearded people. I just——[Laughter.]

Mr. **Lindstrom**. Notice the head patterns on top. [Laughter.]

Mr. **Dornan**. Four.

Dr. **Schuster**. Well, I hate to disprove your correlation, but I have five. [Laughter.]

Mr. **Dornan**. Do you believe this? Four, five, nine, 15, 21 and two on the first go-around. Twenty-three children. I hope you've been as lucky as I have with my five and a sixth which are coming around the second cycle.

I don't know what I did right nor does my wife. We just feel this healthy guilt because we're so lucky. Now I look at this marketing technique with young people, and I hate to sound naive. But until Senator Backus' wife—I mean his sister who lives in my district, told me this, I didn't think any drug person ever gave away a nickel of anything.

And do you know why? Because of all the movies and TV shows we've seen where the guy is coming to collect his debts and blows your brains out.

Now, I'm sitting here thinking, if there were an open bar, Joe's Local Bar, which he was giving away liquor to anybody under 15 to get them used to coming to the local watering hole, people would be outraged.

And then I stopped to think about some good conservative friends I have, who are also friends of the First Lady and the President, and I've actually been to affairs in my district where they do give away free beer.

Now, they would, you know, go wild if they were giving it to children. But here was this afternoon beer festival and the beautiful Hispanic affairs, and so forth, but plenty of free beer.

That's a marketing technique. What are we going to do to analyze this marketing technique and how it starts. Whatever you call this Madison Avenue technique. Is this going to be part of the Conference? I would hope this would be a major part of the Conference because it hit this father and grandfather like a ton of bricks.

We're building this future market by giving expensive stuff away free.

Is that going to be a part of the Conference?

Mr. TRACHTENBERG. I don't know. I think, frankly, in terms of the Conference it's too early to say. I think you hit on a very key issue. I have trouble with my older children when they go down to Ft. Lauderdale on spring break, knowing that the beverage industry is handing out free beer.

I think that hits a little bit closer to home than even the other three things that you referred to, Mr. Dornan. But, you know, I think what you really underscore is the close interrelationship between the supply side, the "cop" side and the role of interdiction on this issue.

I think not only ought there be severe penalties for distribution, but I think they need to be enforced. I think this can't be tolerated at any level. I think the other side of it is whether it's "just say no" messages or other peer assistance strategies—that whatever invulnerability we can build in our children against drugs, that supply reduction needs to continue to be strengthened and developed.

Mr. DORNAN. Well, these are called nonviolent crimes, marketing free drugs to kids. When I watched this national show and saw Crossfire last night, there was an intelligent gentleman there sitting on the program saying that we couldn't put any people in prison anymore for nonviolent crimes because the prisons were filled.

So what are we going to do, just keep building prisons? And yet sort of pillory stocks, public scourging, tar and feathering, I don't know what you do with a child corruptor who is passing out free brain destructive material to 6th and 7th graders.

Mr. BESTEMAN. Well, look at it just a little bit differently also. If you go into a treatment center, I challenge you to ask everybody in the treatment center who supplied their first dose of illegal substance.

And it's usually a friend who shared it with him and it is not perceived by the recipient, necessarily. And very often, by the—as marketed. Now the difference is that as we've gotten a little more sophisticated, we've seen marketing as a deliberate move.

But always—I mean, historically, as patient after patient is asked, who were you with the first time you took heroin. There were three friends on a rooftop.

Mr. DORNAN. And it's always free, isn't it?

Mr. BESTEMAN. It's always free. Well, I can't say I don't know of anybody. I know of very few who went out and bought their first dose of anything. So that this has been a—frankly, to go back, this is the way we, individually, market it to each other as 14-year-olds when one of us got hold of a package of cigarettes.

Mr. DORNAN. It's called sharing the misery. It's a subconscious form of automatic marketing, automatic marketing because people, I think, still in our society, have a guilt feeling about altering their consciousness. So they want to share it with other people.

It's like the joke that is going around in all the single bars now, in which a guy who picked up Miss America in a bar three or four years ago. And after the night, he finds, in lipstick on his bathroom mirror, "Welcome to the AIDS generation."

It is called sharing the misery. And whether that's just folklore or not, it is all subconscious marketing. The sharing of misery as a deliberate marketing technique. How many of your 23 children are going to escape, at some age level—particularly the grandkids coming up. How are they ever going to escape their share of misery marketing combined with more deliberate marketing of drugs? These are tough decisions to make after you've lost your innocence.

It's incredible. I just hope the White House Conference gets the most extensive public airing that any conference has ever had in the history of the country.

You're going, right, Ben? You're going to share a role?

Mr. GILMAN. I hope so.

If the gentleman will yield. Mr. Trachtenberg, getting back to the White House Conference, I note that counsel has just pointed out to me that it calls for a final report and followup, and the final report no later than six months after the effective date of this Act.

Now, the effective date of the Act, I guess, goes back to October of 1986. We're already approaching the deadline for final report, and you're now talking about a conference that won't start until September.

I'd like to point that out to you and would you please point that out to the White House staff or whoever is working on this, that the legislation does call for a final report within six months of the signing of the final Act.

And also please note that in the legislation, it calls for local officials, governors, department heads, private sector, health people. And you're talking about a 70-member group, I don't know how you're going to include all of those within the confines of the 70-member group.

I hope that you will take a good hard look at what the Congressional intent was and make certain that we're not overlooking any important aspect of the problem.

Mr. TRACHTENBERG. Thank you, Mr. Chairman.

Mr. GILMAN. Any further questions, Mr. Dornan?

[No response.]

Mr. GILMAN. Any questions by counsel or staff?

[No response.]

Mr. GILMAN. If not, we want to thank you gentlemen for taking time out of your busy schedule to come before the Committee.

The Committee stands adjourned.

[Whereupon, at 11:59 a.m., the Committee was adjourned.]

[The prepared statements and submissions for the record follow:]

OPENING STATEMENT
OF
CHARLES B. RANGEL
CHAIRMAN

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

HEARING ON
IMPLEMENTATION OF THE
DRUG ABUSE TREATMENT AND PREVENTION PROVISIONS
OF THE
ANTI-DRUG ABUSE ACT OF 1986

WEDNESDAY, MARCH 11, 1987

Good Morning

Today the Select Committee on Narcotics Abuse and Control continues its series of hearings to review implementation of the omnibus Anti-Drug Abuse Act of 1987 (P.L. 99-570).

The focus of our inquiry this morning is on the treatment and prevention provisions of the Act. These provisions are administered by the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) in the Department of Health and Human Services.

Other sections of the Act deal with reducing drug supply through enforcement, interdiction and international narcotics control and preventing drug use through comprehensive drug abuse education programs. But it is in the sections we are examining today that Congress attempted to provide some much needed assistance for drug addicts and drug-dependent persons, the tragic victims of drug abuse.

From 1980 to 1986, Federal support for drug abuse treatment and prevention services declined by about 40 percent. During the same period of time, the United States was subjected to increasing supplies of illegal drugs. Indicators of abuse rose dramatically. Cocaine deaths and overdoses more than tripled nationwide. Heroin overdose deaths and emergency room episodes jumped sharply. In some of our major urban areas, the increases far outpaced the national averages.

THE INCREASED AVAILABILITY AND GROWING POPULARITY OF CHEAPER AND MORE POTENT FORM OF DRUGS, SUCH AS "BLACK TAR" HEROIN AND "CRACK" COCAINE, ADDED DANGEROUS, NEW DIMENSIONS TO THE DRUG ABUSE PROBLEM. SIMILARLY, THE RISING NUMBER OF INTRAVENOUS DRUG ABUSERS FALLING VICTIM TO THE DREADED AIDS VIRUS CREATED AN ALARMING PUBLIC HEALTH THREAT.

AS A RESULT OF THESE MANY DIFFERENT FACTORS, THE NUMBER OF PEOPLE IN NEED OF HELP GREW DRAMATICALLY AS THE AVAILABILITY OF DRUG ABUSE SERVICES DECLINED. IN MANY PARTS OF THE COUNTRY, LONG WAITING LISTS FOR TREATMENT BECAME COMMON. EXISTING PROGRAMS COULD NOT COPE WITH THE EXCESS DEMAND FOR SERVICES EVEN BY OPERATING ABOVE CAPACITY. THE RESULTING STRAINS ON THE TREATMENT SYSTEM THREATENED THE QUALITY OF CARE FOR THOSE WHO COULD BE SERVED.

THE ADMINISTRATION RESPONDED TO THIS DEEPENING DRUG ABUSE CRISIS BY CALLING IT A STATE AND LOCAL PROBLEM. THE FEDERAL GOVERNMENT WAS FAILING TO MEET ITS OBLIGATION TO STOP THE MASSIVE IMPORTATION AND INTERSTATE DISTRIBUTION OF HEROIN, COCAINE, MARIJUANA AND OTHER DANGEROUS DRUGS. BUT THE ADMINISTRATION DENIED A FEDERAL RESPONSIBILITY TO HELP STATE AND LOCAL GOVERNMENTS COMBAT THIS NATIONAL DRUG ABUSE PROBLEM. AS THE RAGING INFERNO OF DRUG ABUSE BURNED OUT OF CONTROL THROUGH OUR COMMUNITIES, THE ADMINISTRATION WATCHED AND FIDDLED, IGNORING THE PLEAS OF STATE AND LOCAL OFFICIALS FOR HELP.

In the Anti-Drug Abuse Act of 1986 and the omnibus drug supplemental appropriations, Congress provided critically needed funding to expand State and local substance abuse treatment capacity. This increased Federal support was in no way sufficient to address all the unmet needs, but it represented a renewed Federal commitment to helping States and localities provide treatment to those who need and want it.

The Anti-Drug Abuse Act also established a new Office of Substance Abuse Prevention in ADAMHA to expand the agency's role in training, technical assistance, information development and dissemination and a variety of other prevention activities. This new office will be responsible for administering the $20 million program of demonstration grants authorized by the Act for prevention and treatment of substance abuse among high-risk youth.

The Act also authorized a substantial increase in drug abuse research for new initiatives to expand our knowledge of both the causes of drug abuse and the best ways to treat and prevent it.

Our hearing today will review the status of efforts in all these areas. Of special concern to the Committee is why the Administration has requested no additional funding to carry out these expanded treatment and prevention initiatives in fiscal year 1988. Instead, funds provided under the Anti-Drug Abuse Act will be stretched out over two years.

THIS POLICY IN EFFECT REDUCES BY HALF THE LEVEL OF ACTIVITIES THAT CAN BE SUPPORTED UNDER THE ACT. IT TELLS THE AMERICAN PEOPLE THAT THEIR FEDERAL GOVERNMENT IS TAKING A "BUSINESS AS USUAL" APPROACH TO THE DRUG ABUSE EMERGENCY. THIS IS NOT THE MESSAGE, OR THE RESPONSE TO THE PROBLEM, CONGRESS INTENDED. THE CUTS IN TREATMENT FUNDING ARE PERHAPS THE CRUELEST OF ALL BECAUSE THEY FALL HEAVIEST ON THOSE WHO MOST NEED HELP -- THOSE WHO ARE STILL ON WAITING LISTS.

OUR WITNESSES TODAY INCLUDE THE ADAMHA ADMINISTRATOR AND A PANEL OF SUBSTANCE ABUSE TREATMENT AND PREVENTION PROFESSIONALS. BEFORE CALLING THE WITNESSES, I YIELD TO ANY MEMBER OF THE COMMITTEE WHO MAY WISH TO MAKE AN OPENING STATEMENT.

OPENING STATEMENT
OF
CONGRESSMAN WALTER E. FAUNTROY
(D.,D.C.)

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

HEARING ON THE
DRUG ABUSE TREATMENT AND PREVENTION PROVISIONS
OF THE
ANTI-DRUG ABUSE ACT OF 1986

MARCH 11, 1987
9:30 A.M.

B-352
RAYBURN HOB

I WANT TO COMPLIMENT CHAIRMAN RANGEL FOR HIS UNCEASING AND THOROUGH EXAMINATION OF ONE OF THE MOST CRITICAL ISSUES OF THIS 100TH CONGRESS--THE FAILURE OF THE REAGAN ADMINISTRATION (IN SPITE OF ALL ITS RHETORIC ABOUT DRUG INTERVENTION, PREVENTION AND TREATMENT) TO SUPPORT THROUGH THE 1988 BUDGET THE NEEDS OUTLINED IN THE OMNIBUS DRUG ABUSE ACT OF 1986 (P. L. 99-570).

THIS HEARING TO EXAMINE THE IMPLEMENTATION OF THAT ACT IN THE AREAS OF TREATMENT AND PREVENTION IS AN IMPORTANT OPPORTUNITY TO HIGHLIGHT AND EMPHASIZE THE NEED VERSUS THE PRESENT CAPACITY OF TREATMENT TO MEET THAT NEED!

TREATMENT AND PREVENTION IN THE ANTI-DRUG ABUSE ACT OF 1986 (P.L. 99-570) PROVIDED MINIMALLY FOR ONLY EMERGENCY NEEDS IN THIS AREA. PRESIDENTIAL BUDGET APPROPRIATIONS FOR FY-88 PROVIDE THE MOST TOKEN, THE MOST MEAGRE RECOGNITION OF THE CRISIS. INSTEAD OF INCREASING WHAT WAS ALREADY AN INADEQUATE FUNDING FOR TREATMENT, IN PARTICULAR, WE FIND A COMPLETE DISREGARD FOR THE WHOLE CRISIS AND THE MOST CYNICAL TOKENISM.

THERE ARE REAL QUESTIONS TO BE ASKED AND ANSWERED IN THE AREA OF TREATMENT:

- WHAT IS OUR PRESENT NATIONAL TREATMENT CAPACITY, AND WHAT KINDS OF FACILITIES AND MODALITIES ARE AVAILABLE AT STATE, COUNTY, CITY LEVELS;

- WHAT IS THE ACTUAL COUNT (BY NARCOTIC IDENTIFICATION) OF THE CASES IN NEED OF TREATMENT;
  (HOW MANY HEROIN CASES; HOW MANY COCAINE CASES; HOW MANY PCP, ETC.)

- Are we meeting these goals of treatment?
- What is available in research in treatment modalities? Are we properly funding research at the National Institutes of Drug Abuse and other health agencies to meet the challenges of this escalating malady--substance abuse?
- How much money is actually presently available to local and state jurisdictions for treatment?
- How much money is actually needed to meet the future demands of treatment?
- Are we really exploring additional sources of revenue to assist funding of treatment?

These are just a few of the questions that I hope will be answered by this morning's hearing.

I would add two other population groups that somehow never get the emphasis that they should have.

- Our prison populations, with the tragic needs for treatment that presently are not being met;
- The drug user who the Military tells us they "return immediately to general society from military service with no attempt at treatment in the services." What are we doing to save these young people through treatment?

WE MUST FACE OUR HUMANE AND MORAL RESPONSIBILITY AS INFORMED AND EMPOWERED LEGISLATORS IN THIS AREA OF FUNDING FOR TREATMENT AND PREVENTION.

I KNOW MANY OF MY COLLEAGUES JOIN ME IN THIS URGENT PLEA. AND I KNOW THAT THE AMOUNT OF SUFFERING IN EVERY SOCIAL STRATA OF THE AMERICAN FAMILY CRIES OUT FOR OUR ASSISTANCE.

LET US MOVE TO ESTABLISH REAL FACTS, REAL FIGURES, AND REAL COUNTS OF WHAT IS NEEDED. AND THEN LET US DEMAND THE AMOUNT OF MONEY NEEDED TO BRING ABOUT THIS LEVEL OF TREATMENT AND PREVENTION RELIEF -- AS QUICKLY AS POSSIBLE.

* * * *

OPENING STATEMENT

OF

THE HONORABLE BENJAMIN A. GILMAN

RANKING MINORITY MEMBER

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

FOR OVERSIGHT HEARING ON

THE ANTI-DRUG ABUSE ACT OF 1986

DRUG ABUSE TREATMENT AND

PREVENTION PROGRAMS

MARCH 11, 1987

THIS IS THE THIRD OVERSIGHT HEARING OF THE ANTI-DRUG ABUSE ACT OF 1986, WHICH WILL FOCUS ON EXISTING AND NEW FEDERAL EFFORTS IN THE AREA OF SUBSTANCE ABUSE TREATMENT AND PREVENTION. IT IS NO SECRET THAT THE NUMBERS OF THOSE ABUSING ILLICIT SUBSTANCES CONTINUES TO RISE, WHILE THE PRICE OF THOSE SUBSTANCES GOES DOWN. THE PROBLEM HAS ESCALATED DRAMATICALLY IN RECENT YEARS, REQUIRING AN ADDITIONAL EFFORT OVER AND ABOVE WHAT HAS ALREADY BEEN INSTITUTED.

IN HEARING AFTER HEARING, THE SELECT COMMITTEE HAS LEARNED OF LENGTHY WAITING LISTS FOR TREATMENT AND PREVENTION ACROSS THE COUNTRY. IT IS A SORRY STATE OF AFFAIRS WHEN ONE FINDS AN INDIVIDUAL, HONEST AND COMMITTED ENOUGH TO ENTER A PROGRAM OF REHABILITATIVE THERAPY, ONLY TO FIND SCORES OF OTHERS STANDING IN LINE AHEAD OF THAT INDIVIDUAL. TRULY, WHAT DOES THIS SAY ABOUT OUR PRESENT SYSTEM?

WE ENCOURAGE PEOPLE TO QUIT, ASSURE THEM THAT HELP IS ON THE WAY, BUT THEN LEAVE THE INDIVIDUAL DANGLING FOR WEEKS ON END.

THESE ARE THE PEOPLE WHO NEED ASSISTANCE THE MOST. INSTEAD, THEY ARE LOSING THE MOST. WHAT IS BEING LOST IS FAITH IN THE COMMITMENT AND INTEGRITY OF THOSE OFFERING ASSISTANCE. THIS VICIOUS CYCLE MUST BE BROKEN, AND SOLUTIONS MUST BE ADDRESSED IN THIS MORNING'S DISCUSSION.

CONGRESS REMAINS THOROUGHLY COMMITTED TO ASSISTING STATES AND LOCAL GOVERNMENTS IN ADMINISTERING THEIR TREATMENT AND PREVENTION PROGRAMS. NOT ONLY FUNDING IS AT ISSUE. NEW MODALITIES AND TECHNICAL EXPERTISE MUST BE MADE AVAILABLE.

THE NEW OFFICE OF SUBSTANCE ABUSE PREVENTION IN ADAMHA HAS BEEN GIVEN A VERY IMPORTANT ROLE IN OUR "WAR ON DRUGS," AND I AM KEENLY INTERESTED IN BEING APPRISED OF ITS AGENDA, TIMETABLE, AND DEMONSTRATION PROJECTS.

I LOOK FORWARD TO HEARING FROM OUR DISTINGUISHED WITNESSES THIS MORNING. I HOPE THAT THEY WILL PROVIDE OUR SELECT COMMITTEE WITH CANDID ASSESSMENTS AS TO HOW OUR NATION CAN BEST TREAT AND REHABILITATE THOSE INDIVIDUALS WHO HAVE BECOME ADDICTED TO DRUGS.

CLEARLY, THE LACK OF FISCAL YEAR 1988 FUNDS AS PROPOSED BY THE ADMINISTRATION CANNOT BE LEFT TO STAND. WE NEGATE OUR OWN EFFORTS TO HELP COMBAT DRUG ABUSE IF WE INSIST THAT FUNDING FOR ONE YEAR BE MADE TO LAST FOR TWO, AND, MORE IMPORTANTLY, SUCH A PERSPECTIVE NEGATES WHAT WE KNOW TO BE THE REALITY OF THE DRUG CRISIS IN THIS COUNTRY.

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STATEMENT OF

WAYNE LINDSTROM, PH. D
CO-CHAIRPERSON
PUBLIC POLICY COMMITTEE
NATIONAL ASSOCIATION OF STATE ALCOHOL
AND DRUG ABUSE DIRECTORS

and

CHIEF
BUREAU ON ALCOHOL ABUSE AND ALCOHOLISM RECOVERY
OHIO DEPARTMENT OF HEALTH

before the

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
U.S. HOUSE OF REPRESENTATIVES

on the

IMPLEMENTATION OF THE ANTI-DRUG ABUSE ACT OF 1986

MARCH 11, 1987

Chairman and Committee Members:

Thank you for the invitation to appear before you today to address the status of the treatment and prevention initiatives authorized by the Anti-Drug Abuse Act of 1986, P.L. 99-570, and to comment on the President's lack of a new budget request for these programs for FY 1988.

My name is Wayne Lindstrom, Ph.D. I am appearing before you today in my official capacity as the Co-Chairperson of the Public Policy Committee of the National Association of State Alcohol and Drug Abuse Directors. I am also representing Ohio's alcohol and drug abuse program of which I serve as the Chief of the Bureau on Alcohol Abuse and Alcoholism Recovery.

As you are aware, the membership of the National Association of State Alcohol and Drug Abuse Directors (NASADAD) is comprised of the State officials designated by the Governor to administer the publicly funded alcohol and drug treatment and prevention services system. NASADAD is a not-for-profit organization; our primary goal is to promote the development of effective alcohol and drug treatment and prevention programs throughout the nation.

Recently, NASADAD has been closely involved in the implementation of the treatment, prevention and education programs authorized by P.L. 99-570. Our National Association serves as a focal point for the exchange of information between and among Federal and State agencies and provides technical assistance on the implementation and coordination of these important programs.

Before I begin our statement, I wish to express the NASADAD membership's sincere appreciation and recognition of the strong leadership role which you and other members of the Committee undertook in the development and passage of the Anti-Drug Abuse Act of 1986. I would also like to note for the record that you have been an outstanding advocate within the U.S. Congress for drug abuse treatment and prevention programs for many years. Your commitment to our programs clearly did not begin or end with the 1986 elections.

Mr. Chairman, the problems of drug and alcohol abuse are truly staggering public health problems. The economic costs of these illnesses to society in the year 1983 alone were over $176 billion. Last year alone, 38 million adults tried an illicit drug. Almost one-third of our college students have used cocaine. Alcohol is the leading cause of death and disability for individuals under the age of 44. It is also the third leading cause of birth defects and the only one that is preventable. Twenty-five percent of the individuals infected with the deadly AIDS virus are intravenous drug users. A minimum of 60 percent of pediatric AIDS cases are related to intravenous drug use by one or both of the parents. Clearly, these illnesses are having a major, catastrophic effect on the health, welfare and competitiveness of our nation.

And yet, Federal support for programs to prevent and treat these illnesses declined 40 percent during the six year period from FY 1980 to 1986. In FY 1986, $1.3 billion were expended for publicly funded drug and alcohol treatment and prevention services. States provided approximately one-half of these resources, the Federal government less than 20 percent.

Last year, when the Anti-Drug Abuse was enacted and included a supplemental, emergency grant program for treatment services, the States were extremely pleased with the prospect of a renewed commitment by the Federal government to assisting States and communities in their efforts to prevent and treat drug and alcohol abuse. We have been asked today to address the impact of these emergency, supplemental treatment grants on the currently overburdened treatment system. Unfortunately, we are not able to provide the Committee with a comprehensive response to your question, since only minimal amounts of these new monies have reached the State level. NASADAD has estimated, however, that an additional 220,000 persons in need of treatment for alcohol and/or other drug abuse problems could benefit from the additional Federal support.

According to the Anti-Drug Abuse Act of 1986, the treatment monies are to be allocated on a two-part formula : 45 percent based on population and 55 percent based on a need and capacity formula. The legislation required that these monies were to be allocated to the States no later than February 27, 1987. As of today, however, only one-half of the States have received a quarter of their population-based award. Also, an application form for the monies to be allocated according to the need and capacity formula (which has yet to be finalized) was not sent to the States until last week.

In my State of Ohio, we plan to distribute the 45 percent of the drug monies to the alcohol and drug mid-management systems that funds local services providers, to develop new and expanded treatment services. We have earmarked one-half of these funds for indigent youth treatment and in urban areas 50 percent of this amount is designated for minority youth. Since the schools are anticipated to identify more alcohol and drug dependent youth due to the distribution of monies from the Drug-Free Schools and Communities Act of 1986, we thought it imperative that we develop increased treatment capacity to serve those youth who are referred by the schools. The Governor's Council on Recovery Services is currently developing recommendations for the expenditure of the 55 percent portion of the supplemental treatment monies. The Council is reviewing recent reports of the Governor's Minority Health Task Force, the Task Force on Adolescent Pregnancy and the Task Force on Family Violence to help determine where this money might have the greatest impact on those in need.

The State Alcohol and Drug Agencies in Ohio are also administering the Governor's discretionary funds under the Drug-Free Schools and Communities Act. Children of alcohol and drug-dependent parents are anticipated to have a priority for these dollars given that they are probably the most at-risk population for alcohol and drug abuse problems. To coordinate the effective expenditure of the criminal justice treatment and education and prevention monies coming into Ohio as the result of the Anti-Drug Abuse Act of 1986 the Governor's Council on Recovery Services is meeting on an on-going basis with all of the related State agencies, the Governor's office and relevant constituency groups.

Perhaps the most critical implementation problem facing the NASADAD membership is the fact that the Administration is deliberately misinterpreting Congressional intent and informing States that they must spend their FY 1987 emergency treatment monies (which were to be allocated by February 27, 1987) over a two-year period. Many States who had planned to immediately spend these much-needed monies are greatly confused and the ability to significantly expand their treatment capacity is being severely diminished. If the States are required to spend the new emergency treatment monies over a two-year period, the impact of the FY 1987 appropriation for this grant program - $163 million - will be reduced by 50 percent.

The ability of States to expand treatment capacity to meet demand for services is also severely diminished by the fact that the Administration has not recommended any new monies for these treatment grants for FY 1988. It is readily apparent that there is no longterm committment from the Administration to provide assistance to our overburdened publicly-funded treatment programs and that the previous committment lasted only three months. States are finding it difficult to secure widespread approval for the opening of new treatment programs or expansion of existing programs if there is only a short term commitment by the Federal government to these programs. States realize that if the Federal funds are withdrawn , they will have to once again make up for the Federal abandonment of the individuals in need of treatment services.

NASADAD recommends that the U.S. Congress immediately take steps to address the major barriers which the States are encountering in their efforts to effectively expand treatment services. We suggest that the Department of Health and Human Services be immediately directed to refrain from telling States to spend the FY 1987 appropriation for these programs over a two-year period. We also suggest that the U.S. Congress make it immediately clear to the States that the Members intend to stand by their already visible committment to drug and alcohol treatment services and that new monies for the continuation and growth of these programs will be forthcoming in FY 1988 and succeeding years.

This year, the U.S. Congress will consider renewal of the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant program which currently serves as the primary source of Federal support for treatment and prevention services. During authorization of the Anti-Drug Abuse Act it was noted that renewal of the emergency, supplemental grant program would also be considered at this time. NASADAD has developed a position paper which outlines our recommendations for the renewal of these important initiatives and have attached a copy of these recommendations for the Committee's review. We propose a three year renewal of the ADMS Block Grant and the emergency, supplemental treatment grants with authorization levels that represent a twenty percent growth in these programs per year. We believe that these recommendations, if adopted, will signal a longterm committment by the U.S. Congress to a strong Federal role in drug and alcohol treatment and prevention services.

NASADAD also supports a three-year renewal of the Federal alcohol and drug research programs: the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). These programs are critical in the establishment of a knowledge base for the alcohol and drug abuse field. The States do advocate, however, for a greater emphasis within the Institutes on applied research in the areas of prevention and treatment. The field is in dire need of quality outcome evaluation studies. We need to know what types of treatment and prevention strategies are the most effective for specific populations. As with the emergency, supplemental treatment monies, the Administration is proposing that the increase in research monies authorized by the Anti-Drug Abuse Act of 1986 be spent over a two-year period. We strongly oppose this strategy by the Administration. These monies were appropriated to be utilized in FY 1987 not over a two-year period.

The Anti-Drug Abuse Act of 1986 also authorized the creation of a new Office of Substance Abuse Prevention (OSAP) within the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). NASADAD has been involved, along with other constituent groups, in the implementation of this new entity's major initiatives. We believe that OSAP has been provided a major opportunity to play a national leadership role in the prevention of alcohol and drug abuse problems. As with the emergency, supplemental treatment grants, however, we are concerned over the President's lack of a new budget request for this program for FY 1988. The total budget for OSAP for FY 1987 is $41.5 million, NASADAD recommends an expansion of this budget in FY 1988 to $65 million. The majority of this increase would be used to expand the demonstration projects for high-risk youth to other youth and adult populations who would also benefit from the demonstration of effective, prevention, intervention and treatment initiatives.

We also suggest that the Congress mandate the coordination of the new education and criminal justice initiatives authorized by P.L. 99-570 with already existing and planned activities to prevent and treat alcohol and drug abuse problems at the State and community level. For example, the

OSAP will be awarding grants directly to individual programs within the States. The formal announcements for the these grants require the applicant to provide evidence of the State alcohol and drug agency's support for the proposed project. This procedure facilitates cooperation with the State's ongoing and planned initiatives, results in the exchange of knowledge and reduces duplication of our efforts to provide a comprehensive array of prevention and treatment services.

NASADAD suggests that a similar coordination provision be mandated in the application process for the education and criminal justice grants to States. We encourage the U.S. Congress to mandate that the State alcohol and drug agency be provided the opportunity to review and comment on the grant proposals or to at least be notified of the award of these grants. Resources to prevent and treat these tragic, costly illnesses are extremely limited and we must assure that a comprehensive approach is undertaken not only at the Federal, but also at the State level. The State Alcohol and Drug Abuse Directors have over two decades of experience in the alcohol and drug abuse field and our knowledge and experiences will certainly be of benefit to those officials who have only recently become involved in our War Against Alcohol and Drug Abuse.

Before closing, I would like to suggest that NIDA be provided Congressional support for an immediate expansion of their epidemiological activities. During discussions surrounding development of the need and capacity formula for the supplemental treatment monies, it was readily apparent that while there exists excellent county level data on the problems of alcoholism and alcohol abuse, there are no national reporting systems in place for the collection of county level data on other drug abuse problems. The Federal government needs to collect data such as the mortality, morbidity and homicide rates resulting from drug abuse and addiction. There also needs to be a process for ascertaining the critical elements to best describe the extent of the drug abuse problem and to discuss the most appropriate methodology for the collection of such data. It should be noted that while we advocate for an expansion of the NIDA epidemiological program, the solution to this problem is not to place mandatory reporting requirements on the ADMS Block Grant program. State agencies already participate on a voluntary basis in a national data collection system on expenditures and clients in the publicly-funded treatment and prevention system. The types of epidemiological data that are needed must be collected from a much broader universe than the publicly-funded treatment system.

Thank you for the opportunity to appear before you today.

TESTIMONY BEFORE

THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

BY

KARST J. BESTEMAN

EXECUTIVE DIRECTOR

ALCOHOL AND DRUG PROBLEMS ASSOCIATION

ON

MARCH 11, 1987

Dear Mr. Chairman and members of the Committee:

Thank you for the opportunity to appear before you and discuss the implementation of the initiative passed and signed into law last fall which were designed to combat drug abuse. The various sections of the law addressed a wide range of programs to prevent drug abuse. This morning I have been asked to confine my remarks to the supplemental block grant, the increased support for research and the implementation of the Office of Substance Abuse Prevention and its programs. These programs are all being managed by the Alcohol, Drug Abuse and Mental Health Administration and its constituent Institutes.

I will begin with the less controversial elements of the program. The National Institute on Drug Abuse has generated a series of grant announcements informing the field of the availability of new research funding and defining subject areas of special interest to that Institute. Because of the application review cycle there is no public awareness of the activity this has generated. I would assume there has been adequate application since we are almost six months from the time sure knowledge of funding was available. Research should have steadily sustained funding to take advantage of incremented findings and new knowledge. It is unlikely that one grant for three years will produce a spectacular breakthrough in understanding addiction. To sustain the interest by senior investigators and attract the brightest young investigators it is important for the Congress to make a continuing commitment to research funding.

The treatment community is eager and insistent that much research effort be devoted to the aspect of matching patients to effective treatment. There is a broadly based desire to have irrefutable proof of treatment effectiveness to destroy the myth that no one recovers from addiction. There is also a sincere desire by the prevention professionals to have well designed evaluation studies of the various prevention and intervention strategies. Anecdotal self reports are simply not sufficient justification in the era of competing demands for scarce resources. It is important that NIDA aggressively address these issues and if the scientific community does not supply well designed research proposals that NIDA initiate request for proposals and use the contracting mechanisms to obtain this important data.

A second responsibility which NIDA research should address is the adequacy of the federal data base. Much of the discussion last summer as the legislative process was underway questioned the need for more effort from the federal government. There were accusations that the initiative was pre-election hype and not sound policy or wise legislation. The questions raised are of concern because that data base which was so carefully crafted and modified during the 1970's was largely abandoned during the block grant era. It is imperative that a treatment system data base be re-established. The systems in place at present all tend toward under-reporting. The dysfunctional drug abuser is not reached through the survey of households and high schools. These data collection techniques are well within the ability of our present instruments. What is needed is a commitment to procure and manage an information system on clients entering and receiving treatment.

The implementation of the Office of Substance Abuse Prevention has been commendable. It has not yet had any positive impact on the communities of the nation. The OSAP organization was forged on reorganization, acting leadership at all levels, a limited mission, and is severely limited by directives on funding from the OMB which the Department of Health and Human Services did not successfully dispute. What was a modest federal prevention initiative for fiscal year 1987 may become an inconsequential effort for fiscal 1987 and 1988. By demanding that the 1987 appropriations be spread over two fiscal years OMB diminished the impact and effectiveness of the office.

The staff has been working diligently to get guidance to the field. It has missed deadlines. Much of this process and its delayed timing can be explained. Much of it is due to an inability of the new and rotating program managers to make a final decision on program priorities. ADAMHA has never had operational responsibility. The history of tne agency has been that of managing through the Institutes. It found itself ill prepared to take on operational responsibilities. Yet within the usual delays of approval for organizations, personnel and space the establishment of OSAP has proceeded at a steady pace.

The major grant program of OSAP now has its announcement circulating to the field. This announcement should generate a large response. With hard work and high quality proposals the monies may flow to communities during the summer and early fall of this year.

The program area where there has been the greatest delay and greatest anxiety has been in distributing the drug services money which was to be distributed to the states for management. ADAMHA distributed the first part of the funds using the block grant formula very promptly. The second distribution has been debated, compromised and is not yet available for use to treat addicts desperately needing treatment. Also because the Administration's budget did not indicate any intent to continue this funding, local programs are reluctant to commit to any substantial expansion of services with the prospect of reducing services within one year. This combination has cast a shadow over what was originally regarded as the first significant treatment expansion in a decade. Program directors in the community are reluctant to expand facilities, staff, and services, when there is no reasonable expectation that these commitments will be sustained.

There is a special concern on my part with the persistent attempt to devise some methodology which can be equated to "need". When Congress passed the law which established the Special Action Office for Drug Abuse Prevention in 1972, it included a formula grant and the requirement that one third of the money reflect need rather than population. The debates generated by this requirement caused acrimony and dissention among the states and between the states and the federal government.

There are many problems with a "need" formula. First, there is no common data base in the fifty states. Second, each state approaches the need seeking a financial advantage. Third, the proposed solution seeks to achieve harmony and not equity.

The drug abuse problem in our country is sufficiently distributed, varied, and substantial that no state is without need. The drug abuse problems are sufficiently costly to the states that none has a surplus of money to use for treating and preventing drug abuse. The major population centers of the country have the larger concentrations of dysfunctional drug abusers and addiction. There is nothing gained programmatically or strategically to use any other criteria than population to distribute block grant funds. Had the Congress and Administration executed the initiative of 1986 on a population base only, all treatment funds could be committed to the community agencies today. Instead, there are major delays in committing funds due to well intentioned efforts to gain small fiscal advantages in the name of need.

I would urge the members of this committee and the Congress to reauthorize this much needed and effective program without any special

conditions of need. This would remove a major impediment to prompt an effective implementation of service programs.

I thank the Chairman and the members of the committee for your kindness in inviting me to testify on behalf of the Alcohol and Drug Problems Association. I would be pleased to answer any questions you wish to ask.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

FOR RELEASE ONLY UPON DELIVERY

TESTIMONY BEFORE

HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

ON

"IMPLEMENTATION OF P.L. 99-570,
THE ANTI-DRUG ABUSE ACT OF 1986"

BY

DONALD IAN MACDONALD, M.D.
ADMINISTRATOR
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

WEDNESDAY, MARCH 11, 1987

"Rayburn H.O.B.
Room B352
9:30 a.m., 3/11/87"

Mr. Chairman, Members of the Select Committee on Narcotics Abuse and Control, it is a pleasure to accept your invitation to provide you with a status report on our activities regarding implementation of P.L. 99-570, the Alcohol and Drug Abuse Act of 1986.

I speak today as Administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) although I am assisting the President in another capacity too. I am sure you will understand as I confine my comments today to ADAMHA and its cooperative efforts with other agencies.

On October 27, 1986, the President signed into law P.L. 99-570 which provided ADAMHA with an additional $241,000,000 in program authorization. Two weeks earlier the Congress in its Continuing Resolution for Fiscal Year 1987 provided an appropriation of $252,000,000 for Drug Abuse Initiative with two year obligational authority through September 30, 1988. In allowing the payout of funds over two years, we believe the Congress sought to assure the funds would be spent efficiently and allow for start up time in the competitive grant and contract areas. These funds will assist in our continuing effort against alcohol and drug abuse by enhancing on-going efforts in treatment, prevention, research, and program coordination.

Treatment, Prevention, and Interagency Cooperation

Since the passage of Public Law 99-570 we have made significant progress toward implementing the provisions of that law.

- A new Office of Substance Abuse Prevention (OSAP) has been created within our Office of the Administrator. Organization development of the office has been completed.
- We have held a national strategy conference with representatives of every major prevention and education group to provide us with expertise from the entire Nation in finalizing plans for education and prevention.
- We have begun distribution of additional block grant funding for emergency substance abuse treatment and rehabilitation. Congress

mandated that these funds be awarded based on two criteria. Forty-five percent of the funds were to be awarded based on population, 55 percent based on need. The latter formula criteria has been accepted by almost all States. We have already issued awards to 45 States under the 45 percent formula. The remainder are in process. Letters to the Governors soliciting applications for this additional treatment funding have been sent out. A decision on the finalization of the 55 percent formula is expected shortly.

o OSAP has forwarded a grant announcement to 4,000 groups or individuals concerning the availability of funds for the new Demonstration Grant for High Risk Youth program. This major new program was allocated $20 million by the Congress. We have 10 procurement actions utilizing half of that money already underway.

o The newly mandated joint national Clearinghouse for Drug and Alcohol Information will be formally established in May of this year. In the interim, staff and functions of the two former institute clearinghouses have been combined, their combined mission expanded, and materials continue to be distributed.

- A plan to coordinate the Anti-Drug Abuse Act efforts of the various Federal agencies has moved beyond the formative stage. Monthly meetings have been held at the Department of Education, and co-chaired by the Department's Special Assistant to the Secretary with OSAP. In addition to HHS, the Department of Education, the Department of Justice and ACTION are regular attendees.

- A transfer of $500,000 to OSAP from the Department of Education will soon be accomplished based on the recent completion of a memoranda of understanding regarding distribution of Department of Education materials.

- NIDA has established a new Office of Workplace Initiatives to coordinate activities both in the public and private sectors to produce a drug-free American workforce. This office is working with the

Department of Labor and OPM to actively provide technical assistance to Federal agencies and the business community.

ADAMHA has developed scientific and technical guidelines for the Federal drug testing programs which will serve as a model for the use of this technology in this country. We are establishing a laboratory accreditation program to insure that laboratories in the U.S. providing such services are of the highest quality technology possible. We are developing a new initiative on employee assistance to insure that every employee who needs help will have access to a high quality program.

- Research funding of additional intramural programs within ADAMHA under the amendments is in the final planning stage. Forty new research projects, three new research centers, as well as new starts in cooperative agreements, small grants, and enhancements of existing intramural research efforts are on the schedule.

Establishment of our new Office of Substance Abuse Prevention was a difficult challenge but by using expediting methods such as temporary details and outside experts the structure is in place and moving into high gear. During these early stages we have been fortunate in receiving the assistance of Dr. Reed Bell of Tallahassee who brings a strong background in substance abuse programs to head up the office.

OSAP has taken on the responsibility of administering the $20 million fund for studies of high risk youths. The money will be focused on:

1. Comprehensive prevention, treatment and rehabilitation demonstration projects -- these will be innovative community-based projects aimed at building linkages and coordination among existing community services.

2. Targetted primary prevention demonstration projects -- innovative models aimed at one or more of the high risk groups specified in the law.

3. Early identification and intervention of children involved or experimenting with gateway drugs.

Additionally, OSAP will be looking to develop training materials for school counselors and day care providers as well as assisting other community-based prevention programs.

Cooperation and coordination are the key words in our overall effort to implement the anti drug abuse iniatitive. ADAMHA and the Department of Justice's Office of Juvenile Justice and Prevention have identified four areas of project cooperation. We are working together on the following projects:

1. Three to six applications currently are under review for high risk youth grants.

2. A joint media effort is already underway for the "Be Smart Don't Start -- Just Say No Campaign," aimed at preventing teens and pre-teens from starting to experiment with alcohol and drugs.

3. The National Institute of Mental Health Center for Violence and Anti-Social Behavior is discussing joint new research efforts with the Office of Juvenile Justice and Delinquency Prevention. This stems from previous NIDA/

Justice research studies investigating the fact that 65 percent of all violent crimes are drug or alcohol related.

4. The Department of Justice and NIDA are jointly funding a specific study of the Epidemiology of Drug Abuse in Minority Communities.

In addition ADAMHA and the Office of Juvenile Justice and Prevention will hold a conference with 50 to 75 experts in substance abuse prevention at the Wingspread Center in Wisconsin in July 1987.

An effective drug abuse prevention program must be developed locally to reflect the specific needs of various components of the community -- public and private schools, police, and parents.

The Department of Education is primarily responsible for encouraging implementation of school-based drug abuse programs that fit within a community context. We are sharing funds from our research in drug abuse curriculum development. In collaboration with them, we are determining the nature and effectiveness of Federal, State, and local drug abuse education and prevention programs.

The cooperative effort with Department of Education has resulted in the creation of eight working groups which meet at least once or twice a month with the aim of avoiding duplication and overlap in providing materials covering substance abuse prevention for school policy, curriculum development, regional workshops and teaching training.

A Department of Education letter distributed nationally now includes pertinent scientific facts for teachers and parents provided by ADAMHA's substance abuse experts. There is another group in ADAMHA specifically focused on evaluation and research to determine what programs work and what programs don't work in the schools.

Research

The National Institute on Alcohol and Alcohol Abuse received $3 million from the initiative which they plan to utilize in studies on the epidemiology of alcohol use. The Institute is attempting to develop an objective marker on alcohol intake. This would greatly increase a physicians ability to determine whether alcohol abuse may be complicating other patient problems.

The National Institute on Drug Abuse received $27 million from the Drug Abuse initiative. These monies will fund 40 new research project grants and 3 new research centers, as well as new starts in cooperative agreements, small grants and contracts, and enhancements of existing intramural research efforts.

The NIDA effort is focused on a study of practical areas such as the efficacy of current drug treatment programs. Little is presently known on the long term effectiveness of treatment programs for abuse of cocaine (or crack), PCP, or designer drugs.

NIDA is also planning to review the potential of sustained delivery systems in drug treatment such as implants and slow release medications. NIDA will also undertake genetic code studies to determine if genes contain a key to identify potential drug abusers.

Because of the rising concern based on the DAWN system reports, NIDA has moved swiftly to determine the relationship of cocaine to heart attacks. They have already issued contracts initiating new research into this vital area.
Our intramural studies in NIDA have demonstrated how cocaine works in the brain. Cocaine or crack causes a process in the brain known as "kindling" which can set the stage for a potentially fatal seizure -- even when the victim has used less than a regular dosage. This effect enlightens us on the horrifying risks for cocaine users.

NIDA grantees, too, are making progress in the effort to treat PCP victims. They have developed a method to stimulate antibodies to promote more efficient secretion of PCP from the body. If effective at higher levels with humans this could, potentially, save many users from death through overdose.

I have touched, I believe, on most all of the major activities funded by the 1986 anti-drug initiatives. Thank you Mr. Chairman, I would be happy to answer your questions.

STATEMENT OF THE HONORABLE JOSEPH J. DIOGUARDI BEFORE THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Mr. Chairman, again I would like to commend you and Mr. Gilman for holding these investigative hearings on where we stand with the Federal assistance Congress provided last October on an emergency basis. I believe we are all in agreement that it is vital that the funds we slated for a front line defense on the war on drugs get to the streets as soon as possible and I hope these hearings will help accelerate that process.

The area of drug treatment and rehabilitation is one that has been of great importance to me for some time. It was through my work as a Board Member of the Phoenix House that my eyes were opened to the terrible personal tragedies that are caused by drug abuse. I cannot stress enough the absolutely critical need to get each and every dollar slated by Congress for drug programs to the areas of our country that are in great need.

I have joined with Senators D'Amato and Moynihan, in writing to Dr. Macdonald expressing displeasure with the proposed formula for distribution of the state grants for rehabilitation and treatment. Great care was taken in the late hours of the Conference of the Drug Bill to ensure that every state was adequately recognized with this form of funding. However, certain states with desperate needs were further recognized and targeted to receive a larger portion of these funds. New York State is one of those states with desperate need at this time. Treatment centers are full to overflowing and waiting lists are months and, in instances, years long.

I come here today to ask Dr. Macdonald the same question I asked over a month ago, why is New York State not recognized with a larger portion of the needs based segment of the treatment and rehabilitation grants, as was the intent of the Congress expressed in the Anti-Drug Abuse Act, and why is New York State being penalized for the exemplary effort it has undertaken in it own right in this area?

I appreciate the challenge that confronts this administration in the distribution of this awesome amount of funding. However, I have been frustrated time and again by the inadequate job that is being done to get the funds to where they are desperately needed.

SUBMISSIONS FOR THE RECORD

EMERGENCY SUBSTANCE ABUSE TREATMENT AND REHABILITATION BLOCK GRANT PROGRAM

FACT SHEET

Public Law 99-570, "Anti-Drug Abuse Act of 1986", amends Title XIX of the Public Health Service Act by adding Part C--Emergency Substance Abuse Treatment and Rehabilitation--which increases the Part B ADMS Block Grant allotment and creates a new substance abuse block grant which authorizes an allotment to States partly by population and partly by need.

The relevant portions of Public Law 99-570 (including a section citation to Title XIX of PHS Act) are:

1. Authorization (Section 1921(a)):

Subject	Dollar Appropriation (Million)
Increase existing Part B, ADMS Block Grant by 6% of the amount appropriated for Part C	$ 13.86
Substance Abuse Treatment Enhancement: 45 percent ($73,285,000) by population 55 percent ($89,570,000) by need related criteria (HHS Determined)	162.86

2. Substance Abuse Treatment Enhancement (Section 1921(b)):

   This section creates a substance abuse treatment and rehabilitation block grant. Forty-five percent of the amounts appropriated for the program are to go to the States based on population. No State will receive less than $50,000.

   Fifty-five percent of the amount appropriated is to go to the States based on need. Need is to be determined by the Secretary after considering: Demand (Section 1921(b)(3)(A)); Capacity (Section 1921(b)(3)(B)); and Ability (Section 1921(b)(3)(c)). A formula to allocate will be developed utilizing need related criteria pertaining to alcohol and drug abuse within each State.

3. Pertinent Provisions (Section 1921(c)(4)):

   The provisions of Title XIX, Part B, ADMS Block Grant which are not inconsistent with Part C shall apply.

4. APPLICATIONS (SECTION 1921(D)):

TO OBTAIN AN ALLOTMENT, EACH STATE SHALL SUBMIT AN APPLICATION WHICH INCLUDES THE FOLLOWING:

(A) SUCH INFORMATION AS THE SECRETARY MAY PRESCRIBE, INCLUDING INFORMATION NECESSARY TO DETERMINE DEMAND, CAPACITY AND ABILITY, AND

(B) A DESCRIPTION OF THE MANNER IN WHICH THE PROGRAMS AND ACTIVITIES WHICH WILL BE CONDUCTED WITH PAYMENTS WHICH WILL BE RECEIVED UNDER THIS BLOCK GRANT WILL BE COORDINATED WITH OTHER PUBLIC AND PRIVATE PROGRAMS AND ACTIVITIES DIRECTED TOWARD INDIVIDUALS WHO ABUSE ALCOHOL AND DRUGS, AND

(C) A DESCRIPTION OF HOW THE STATE WILL ASSURE CONSULTATION WITH LOCAL GOVERNMENTS AND PUBLIC AND PRIVATE ENTITIES, INCLUDING COMMUNITY BASED ORGANIZATIONS, INVOLVED IN THE PROVISION OF SERVICES FOR THE TREATMENT AND REHABILITATION OF ALCOHOL ABUSE AND DRUG ABUSE, IN THE PREPARATION OF ALL APPLICATION STATEMENTS, AND

(D) A DESCRIPTION OF THE MANNER IN WHICH THE STATE WILL EVALUATE PROGRAMS AND ACTIVITIES CONDUCTED WITH PAYMENTS RECEIVED UNDER THIS BLOCK GRANT, AND ASSURANCES THAT THEY WILL REPORT PERIODICALLY TO THE SECRETARY ON THE RESULTS OF SUCH EVALUATIONS, AND

(E) ASSURANCES THAT PAYMENTS MADE TO THE STATE UNDER THIS BLOCK GRANT WILL SUPPLEMENT AND NOT SUPPLANT ANY STATE OR LOCAL EXPENDITURES FOR THE TREATMENT AND REHABILITATION OF ALCOHOL ABUSE AND DRUG ABUSE THAT WOULD HAVE BEEN MADE IN THE ABSENCE OF SUCH PAYMENTS, AND

(F) ASSURANCES THAT THE STATE WILL COMPLY WITH ALL PROVISIONS OF PART B OF TITLE XIX OF THE PUBLIC HEALTH SERVICE ACT NOT INCONSISTENT WITH PART C AS THESE PROVISIONS APPLY TO ALLOTMENTS MADE UNDER SECTION 1921.

IN ADDITION, EACH STATE SHALL PROVIDE THE IDENTITY OF THE STATE ENTITY TO RECEIVE THE EMERGENCY SUBSTANCE ABUSE TREATMENT AND REHABILITATION BLOCK GRANT.

TO RECEIVE THE 55% PORTION OF THE PART C BLOCK GRANT THAT "SHALL BE ALLOTTED BY THE SECRETARY TO STATES ON THE BASIS OF THE NEED OF EACH STATE," EACH STATE WILL HAVE TO PROVIDE CERTAIN INFORMATION. THE REQUEST FOR APPLICATION, WHICH IDENTIFIES THE NECESSARY INFORMATION, WILL BE SENT TO STATES WHEN DEVELOPED. STATES WILL BE GIVEN ADEQUATE TIME TO PREPARE THEIR APPLICATION.

5. ADMINISTRATIVE COSTS (SECTION 1921(F)):

NOT MORE THAN TWO PERCENT OF THE AMOUNT PAID TO EACH OF THE RECIPIENTS UNDER PART C MAY BE USED FOR ADMINISTRATIVE COSTS.

6. Use of Funds (Section 1921 (e)):

The amounts paid to a State under this block grant may be used for alcohol abuse treatment and rehabilitation programs and activities including:

(a) Activities to increase availability and outreach of programs provided by major treatment centers and regional branches of such centers which provide services in a State to reach the greatest number of people; and

(b) Activities to expand the capacity of alcohol abuse and drug treatment and rehabilitation programs and facilities to provide services for alcohol abusers and drug abusers who have been refused treatment due to lack of facilities; and

(c) Activities to provide to access to vocational training, job counseling, and education equivalency programs to alcohol abusers and drug abusers to enable them to become productive members of society.

7. Training and Technical Assistance (Section 1921(g)):

The Secretary may provide training and technical assistance to recipients in planning and operating activities to be carried out under Section 1921.

8. Data Collection (Section 1921(h)):

The Secretary may conduct data collection activities to carry out Section 1921.

Proposed 1987 Block Grant and Substance Abuse Awards 02-Dec-86
(Dollars in thousands)

State	ADMS Block Grant Award $495M	 Award $13.860M	 Total Award	Sub. Abuse Award (45%)	Total ADMS Blk. and Sub. Abuse
Alabama	$9,422	$261	$9,683	1,213	10,896
Alaska	2,102	25	2,127	157	2,284
Arizona	9,072	189	9,261	962	10,223
Arkansas	6,441	155	6,596	712	7,308
California	49,338	1,394	50,732	7,956	58,688
Colorado	7,068	176	7,244	974	8,218
Connecticut	7,043	160	7,203	958	8,161
Delaware	1,441	35	1,476	188	1,664
District of Columbia	2,478	31	2,509	189	2,698
Florida	24,266	645	24,911	3,430	28,341
Georgia	11,179	358	11,537	1,803	13,340
Hawaii	2,848	59	2,907	318	3,225
Idaho	1,676	64	1,740	303	2,043
Illinois	19,697	634	20,331	3,481	23,812
Indiana	19,643	329	19,972	1,659	21,631
Iowa	2,973	171	3,144	870	4,014
Kansas	4,003	139	4,142	739	4,881
Kentucky	4,606	240	4,846	1,124	5,970
Louisiana	5,752	278	6,030	1,352	7,382
Maine	3,759	71	3,830	351	4,181
Maryland	4,913	234	5,147	1,325	6,472
Massachusetts	18,351	307	18,658	1,757	20,415
Michigan	16,024	519	16,543	2,743	19,286
Minnesota	4,981	236	5,217	1,265	6,482
Mississippi	5,211	184	5,395	789	6,184
Missouri	9,850	292	10,142	1,518	11,660
Montana	2,172	52	2,224	249	2,473
Nebraska	2,705	94	2,799	485	3,284
Nevada	2,916	52	2,968	282	3,250
New Hampshire	3,864	55	3,919	301	4,220
New Jersey	20,787	389	21,176	2,282	23,458
New Mexico	4,967	93	5,060	438	5,498
New York	40,438	944	41,382	5,367	46,749
North Carolina	11,054	389	11,443	1,888	13,331
North Dakota	1,180	41	1,221	207	1,428
Ohio	23,810	623	24,433	3,242	27,675
Oklahoma	7,846	197	8,043	996	9,039
Oregon	5,990	159	6,149	811	6,960
Pennsylvania	25,359	681	26,040	3,577	29,617
Rhode Island	4,437	55	4,492	292	4,784
S. Carolina	6,744	218	6,962	1,010	7,972
S. Dakota	3,116	45	3,161	214	3,375
Tennessee	7,865	302	8,167	1,437	9,604
Texas	21,788	938	22,726	4,940	27,666
Utah	3,855	107	3,962	496	4,458
Vermont	3,325	33	3,358	162	3,520
Virginia	8,452	317	8,769	1,722	10,491
Washington	9,066	247	9,313	1,331	10,644
W. Virginia	4,320	128	4,448	584	5,032
Wisconsin	5,318	277	5,595	1,441	7,036
Wyoming	778	29	807	154	961
American Samoa	17	2	19	50	69
Guam	539	7	546	50	596
No.Mariana Islands	32	1	33	50	83
Puerto Rico	6,942	186	7,128	991	8,119
Trust Territ.	66	7	73	50	123
Virgin Islands	1,115	6	1,121	50	1,171
Total	495,000	13,860	508,860	73,285	582,145

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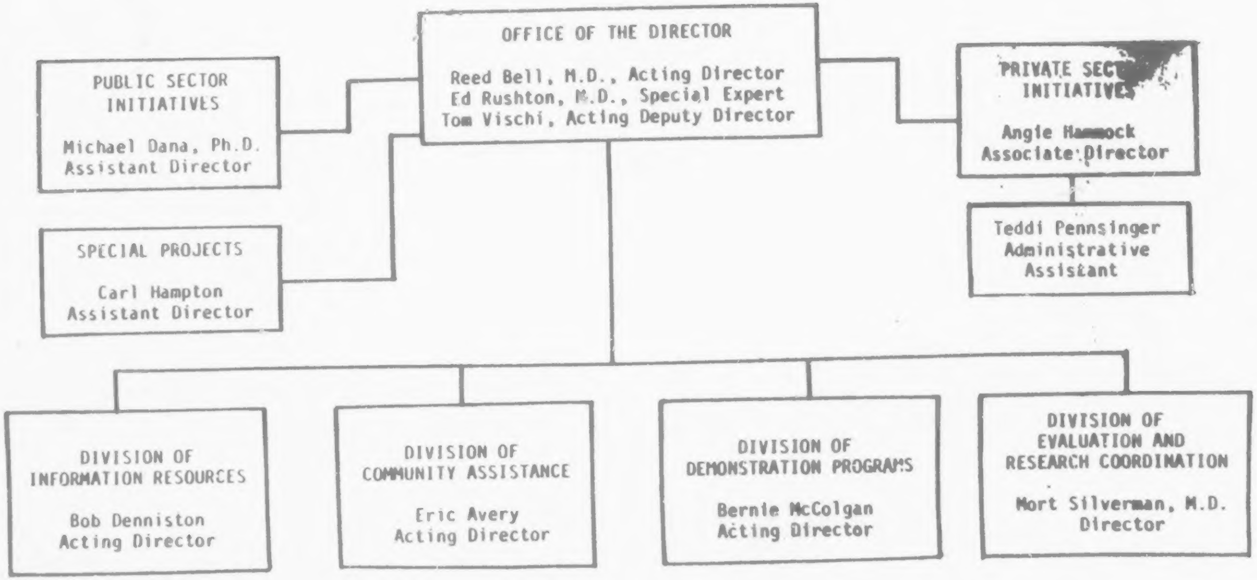
OFFICE FOR SUBSTANCE ABUSE PREVENTION


OFFICE OF THE DIRECTOR
Reed Bell, M.D., Acting Director
Ed Rushton, M.D., Special Expert
Tom Vischi, Acting Deputy Director
PUBLIC SECTOR INITIATIVES
Michael Dana, Ph.D.
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DIVISION OF COMMUNITY ASSISTANCE
Eric Avery
Acting Director
DIVISION OF DEMONSTRATION PROGRAMS
Bernie McColgan
Acting Director
DIVISION OF EVALUATION AND RESEARCH COORDINATION
Mort Silverman, M.D.
Director

The Office for Substance Abuse Prevention

- The Anti-Drug Abuse Act of 1986, P.L. 99-570, created the new Office for Substance Abuse Prevention ("OSAP") and provided a detailed outline of the responsibilities of this new office which is charged with consolidating, coordinating, and supporting the Agency's on-going drug abuse and alcohol abuse direct prevention program activities as well as implementing new prevention initiatives in these areas.

- The efforts include materials development and dissemination (including audiovisuals); technical assistance; training; data collection; evaluation; development of model community programs; and demonstrations of effective prevention programming for high-risk youth. These efforts will be implemented so as to minimize duplication across agencies and departments and assist other departments and agencies in their programs.

- After reviewing the state of the art internally and holding a national conference to gain a clear understanding of the Nation's needs, the OSAP has selected ten major target program areas to address the legislative mandate as those most likely to produce the beneficial results intended. These are as follows:

  1. Demonstration Projects for High Risk Youth which include grants to public and nonprofit private entities for projects to demonstrate effective models for prevention, treatment, and rehabilitation of drug abuse and alcohol abuse among high risk youth, including, e.g., children of substance abusers, children at risk of abuse/neglect and children who do not attend or are at risk of dropping out of school.

  2. A School Initiative which includes efforts to develop and disseminate drug and alcohol prevention material to parents and school personnel through such means as technical assistance, in-service training packages, and audio-visual development aids. Efforts will be coordinated with the Office of Education.

  3. Special Population activities to support skill building workshops and conferences for special population groups and the development of State-of-the-art materials and technology.

  4. Parents and Community Organizations programs to support development of parent training focusing on parent support groups, and national, regional, and local workshops to enhance parent organization capabilities and effectiveness.

  5. A Health and Legal Professionals/Youth Initiative which will support conferences and a youth initiative through workshops, training and networking.

  6. An Alcohol and Drug Abuse Clearinghouse which will, as mandated in the law, develop, collect, and disseminate publications, educational cirricula, and other materials on drug and alcohol abuse prevention/intervention.

7. A Media Activities program which will develop new and expand existing NIDA/NIAAA campaigns as well as review and repackage private sector campaigns.

8. A Publications program to provide writing, editing, and printing of publications.

9. An Evaluation and Planning effort to develop and evaluate instruments/protocols and assess effectiveness of demonstration grants for high risk youths.

10. Office of the Director activities which will support White House and other regional conferences aimed at encouraging corporate, foundation, and other private sector groups.

Summary of OSAP Funding

Demonstration Grants for High Risk-Youth......	$20,000,000
Direct Prevention Activities...............	21,580,000
Transfer of Prevention Funds from Institutes....	4,489,000 1/
Drug Abuse Demonstration Grants (from Conference Action...................	6,500,000
Total.............	52,569,000
Minus Workplace and Epidemiology initiatives.	(4,000,000)
Balance, OSAP......	$48,569,000

1/ Includes 1) $4,444,000 transferred from the NIDA and NIAAA direct operations accounts and, 2) a comparable increase of $45,000 for the Working Capital Fund.

Drug Abuse Initiative — Research Increases

- The Continuing Resolution added $30 million to enhance both the NIDA and NIAAA research efforts — $27 M for NIDA and $3 M for NIAAA.

- This increase will fund approximately 40 new research project grants and 3 new centers, as well as other new starts in cooperative agreements, RSDA, small grants, and contracts, and provide enhancements to the NIDA intramural research program.

- Within NIDA, research efforts under the initiative are focused on developing more effective methods of preventing and treating drug abuse with emphasis on those areas which offer the promise of providing practical results in the near future. These areas include:

  -- Research on determining the efficacy of current drug abuse treatment programs. Although research has demonstrated the effectiveness of treatment programs for narcotics users, little is presently known about the effectiveness of new treatment techniques for the treatment of cocaine users, PCP users, as well as users of the so-called "designer drugs". Nor do we know the effectiveness of these programs for the treatment of adolescents, women, or other "non-traditional" drug users. This expanded research will provide State and local officials needed information to better and more cost-effectively meet the treatment needs of all who require these services.

  -- Expanded efforts to develop new, more effective drug abuse treatment programs. Recent advances, such as the development of sustained release delivery systems for treatment drugs, have greatly increased the possibility of making significant improvements in the effectiveness of drug abuse treatment programs. The availiability of these sustained release delivery systems has the potential for improving patient compliance in treatment regimens as well as lowering the overall cost of treatment by increasing the number of patients any one treatment program could treat.

  -- Expanded efforts to identify those individuals most at risk of drug abuse. Despite the high level of drug use in our society, we also know that most people do not use drugs, and that even among those who try drugs, relatively few go on to compulsive use. There is a belief that genetic factors, as with alcoholism, may also play a role in the disposition of some individuals to drug abuse. Recent advances in the basic biological sciences such as the identification of many of the genes which code for endogenous opiate peptide and their receptors have greatly enhanced research efforts in this area.

- Within NIAAA, the increased funding will allow new initiatives in the areas of prevention research. Efforts include the following:

  -- Research on the determinants of alcohol consumption. Although the patterns of alcoholic drinking is known, what must further be explored is precisely when alcoholics drink, how their intake relates to food and water intake, as well as several other factors. With both nutritional and endocrine data, the possibility of meaningful dietary and pharmacological intervention in alcoholism can be considered.

-- **Enhanced research** on the development of an objective marker for **alcohol intake.** This is one of the most urgent research goals in all of alcoholism research. The need for an objective marker is keenly felt in treatment-outcome evaluation, in the epidemiology of alcohol use, in the evaluation of the possbile effect of moderate drinking on the fetus, and in the clinical decision when alcohol may be, but does not have to be, the source of a patient's symptoms.

March 10, 1987

Select Committee on Narcotics Abuse and Control

Background Information on Treatment and Prevention Initiatives in the Anti-Drug Abuse Act of 1986

Funding

Alcohol, Drug Abuse and Mental Health Administration
(Budget Authority, $ in Millions)

	1987 Drug Initiative	1988 Request
Treatment, Grants to States (ADMS Block Grant	(495.0)	(495.0)
Add-on to ADMS Block	14.0	-0-
New Treatment Block	163.0	-0-
Office of Substance Abuse Prevention	22.0	-0-
Demonstration Projects for High-Risk Youth	20.0	-0-
Drug Abuse Research	27.0	-0-
Alcohol Abuse Research	0	-0-
Program Management	3.0	-0-
(Transfer to the VA)	(10.0)	(-0-)
Total	252.0	-0-

The Anti-Drug Abuse Act of 1986 and the omnibus drug supplemental appropriation provided $262 million to the Department of Health and Human Services for expanded drug abuse treatment and prevention (including research) initiatives. Of this amount $10 million was earmarked for transfer to the Veterans Administration to support services for drug and alcohol dependent veterans. The remainder is for programs administered by the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA).

To assure that funding provided in last year's bill would not lapse, Congress made the appropriations available for two fiscal years. While there is little legislative history on this point, the concern was that some of the funds provided, such as the amounts for the new demonstration grants, might not be fully obligated by the end of FY 1987.

The Administration has not sought any new funds for 1988 to continue the expanded treatment and prevention initiatives authorized in the Anti-Drug Abuse Act. Rather, citing the two-year appropriations language, the Administration has decided to stretch out over a two-year period the new funding provided last year. The effect of this policy is to cut in half the potential level of treatment services and other activities that can be supported.

Treatment

From 1980 to 1986, Federal support for drug abuse services declined by approximately 40 per cent. This decline, coupled with rising drug abuse and increased demand for treatment services, has created enormous strains on the public treatment system operated by States. Long waiting lists for treatment have become common in many areas.

Since 1981, the primary mechanism for Federal support to State drug abuse service efforts has been the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant (Part B). This block grant combined former categorical programs for these three disabilities.

In the Anti-Drug Abuse Act of 1986, Congress added a $14 million increment to the ADMS Block Grant for 1987. In addition, Congress authorized a new emergency substance abuse treatment and rehabilitation block grant (Part C) to expand drug and alcohol abuse services by the States.

According to the law, 45 percent of the new Part C Block Grant is to be allocated to the States on the basis of population. Fifty-five (55) percent is to be allotted to the States on the basis of need. For fiscal year 1987, $162,855,000 is available for the total program. This amounts to $73,285,000 for the population portion, although no State will receive less than $50,000, and $89,570,000 for the needs-based portion.

The law requires that allotments and payments for the 45 percent population-based share of the grant be made at the same time as the allotments and payments for the existing Part B ADMS Block Grant program. As of March 2, 1987, all but five States had applied for the funds available under the population-based portion of the new grant (45 percent). The five States are: Alaska, California, North Dakota, Wyoming, and the District of Columbia. This means that these jurisdictions have also not received their ADMS Part B Block Grant funds for 1987.

Funds for the 55 percent component have not as yet been distributed. This is because the criteria for the determination of State need are still being developed by the Secretary of Health and Human Services.

The original formula proposed by the Secretary in late January considered State population (between 14 and 44 years of age), the number of treatment admissions to publicly funded alcohol and drug treatment programs, the total level of State funding for such programs, and State per-capita income. Several States criticized the factors selected to determine need and the way in which these factors were used in the formula. For example, under the original proposal States with high per-capita income and a high level of State funding for treatment were viewed as having less need. Some States felt this penalized them for having contributed substantial amounts of their own resources to meet their substance abuse needs.

The Secretary's decision on a revised needs formula is expected imminently, after which States may apply for their allocation.

The Administration's decision not to request any additional funding or reauthorization of the new block grant will substantially limit States' abilities to expand their treatment services. At the same time, the Administration's request for the ADMS block grant is frozen at the 1987 level of $495 million.

As a result of these decisions, the amount of funds available to the States for drug abuse, alcohol abuse and mental health services in each of 1987 and 1988 will be less than the total available for these three disorders in 1980.

With the level of funding for the new treatment block grant cut in half and the program's reauthorization in doubt, many States are having serious problems planning how best to use the funds.

A separate fact sheet on the new treatment block grant is attached.

Office for Substance Abuse Prevention (OSAP)

Establishment. The new Office for Substance Abuse Prevention created by the Act is intended to provide higher visibility and funding to Federal drug and alcohol abuse prevention efforts. The activities of the Office include: sponsoring regional prevention workshops; coordinating research findings; developing and disseminating effective prevention materials; supporting clinical training; creating radio and TV public service announcements on drug abuse prevention; supporting the development of model community-based prevention programs; and conducting training, technical assistance, data collection and evaluation.

A separate fact sheet and organization chart for OSAP is attached.

Clearinghouse. OSAP will administer the new clearinghouse for drug and alcohol abuse information mandated by the Anti-Drug Abuse Act. This new clearinghouse combines and expands the separate drug and alcohol clearinghouses previously maintained by NIDA and NIAAA, respectively. The new clearinghouse will disseminate information on the health effects of alcohol and drugs, information on successful alcohol and drug abuse prevention curricula, and information on effective and ineffective school-based prevention programs. The Department of Education will provide materials for distribution by the clearinghouse and also defray part of the costs of the clearinghouse.

Demonstration Grants. The Act earmarks $20 million for a new program of grants to demonstrate effective models for prevention, treatment and rehabilitation of drug and alcohol and drug abuse among high risk youth. OSAP will administer this program.

As a result of the Administration's decision not to seek additional funding for this program, only one-half of the amount appropriated can be used to fund new projects, with the remainder to be used for second year project costs.

An announcement for the high-risk youth demonstration grant program was sent out in February 1987. Applications are due in by May. They will be reviewed in June and July with project awards made in September.

Drug Abuse Research Initiative

The Anti-Drug Abuse Act provided $27 million in new funding to expand drug abuse research by NIDA (the National Institute on Drug Abuse). Since no money was provided to manage these additional research projects, NIDA has shifted $1 million to its direct operations line, leaving $26 million for new projects.

As with the demonstration grants, NIDA may only use $13 million for new projects in 1987 with the remaining $13 million to be used to fund second year project costs. This limitation means that NIDA will only be able to fund 34 new grants out of last year's drug bill. Absent this restriction, NIDA could fund substantially more new grants of the same high quality characteristic of NIDA's research program.

NIDA has released 16 new research grant announcements. Awards will be made in August/September 1987.

A separate fact sheet on NIDA's research initiatives is attached.

Key areas for investigation identified by the Select Committee's hearings are the development of effective treatment and prevention approaches. Drug abuse professionals in the field express a great need to know what types of approaches work best for what types of clients. Information on effective cocaine treatment modalities is especially needed given the rise in cocaine abuse.

Expanded data collection efforts on clients in treatment and program capacity is also needed. One of the problems in selecting appropriate criteria to measure need for the needs-based portion of the new treatment block grant has been the lack of a solid drug abuse data base.

LEGISLATIVE RENEWAL OF THE FEDERAL ADMS BLOCK AND SUPPLEMENTAL TREATMENT GRANTS FOR DRUG AND ALCOHOL SERVICES:

THE NASADAD POSITION FOR THE 100th CONGRESS

GOAL: To secure an extended renewal of the ADMS Block Grant program and a consolidation of the supplemental treatment grants authorized by P.L. 99-570 into the Block Grant authority. The authorities for the ADMS Block Grant (Part B, Title XIX of PHS Act) and the supplemental treatment grants (Part C, Title XIX of PHS Act) expire at the end of the current fiscal year. These programs are the primary source of Federal support for publicly-funded drug and alcohol treatment and prevention services.

RECOMMENDATIONS:

1. Three-Year Renewal of the Program - FY 1988 though FY 1990

   Since its initial authorization in 1981, the ADMS Block Grant program has been authorized in three year increments. NASADAD recommends an additional three year renewal for this program. Any shorter period of time would seriously interfere with the stability of the program and could potentially disrupt the State planning process if major changes in the program were enacted on an annual basis. A renewal period longer than three years could potentially be disadvantageous if changes were made in the authorizing legislation which had a serious negative impact on the States.

2. Renewal and Consolidation of the Emergency Supplemental Treatment Grants into the Alcohol and Drug Portion of the ADMS Block Grant Authority

   The legislative authority for the Supplemental Treatment Grant program authorized by the Congress in P.L. 99-570, "The Anti-Drug Abuse Act of 1986," should be consolidated into the alcohol and drug portion of the overall ADMS Block Grant statute. This consolidation would reflect the need for this program to be an integral component of Federal support for drug and alcohol treatment services and simplify grants management activities at Federal, State and community levels.

   Since the supplemental treatment grants are not bound by the many set-aside provisions of the ADMS Block Grant authority, i.e. services for women, prevention, etc. there should be two separate sections and authorities in the overall statute - one for the ADMS Block Grant and one for the supplemental treatment grants.

3. Authorization Levels Should Permit (At A Minimum) A 20 Percent Growth In The Program*

   FY 1988 - $ 806 million
   FY 1989 - $ 968 million
   FY 1990 - $1,161 million

   *(Funding For the Supplemental Alcohol and Drug Treatment Grant program is factored into the authorization request.)

4. Maintenance of the Current Structure of the ADMS Block Grant With its Three Components - Alcohol, Drug Abuse and Mental Health

NASADAD recommends the continuation of the current structure of the ADMS Block Grant with its three components - alcohol, drugs and mental health. At first glance, it may seem appropriate to administratively separate the alcohol and drug components of the Block Grant from the mental health component. However, since authorization of the ADMS Block Grant in 1981, systems of allocation and coordination have been developed at the State and local levels among the three disabilities that would be disrupted by a division of the components with little or no benefit accruing from the change. In addition, there exists the potential to foster an increasing awareness at the State and community level of the needs of the dually-diagnosed; those individuals who are alcoholic and/or addicted to other drugs and who are also mentally ill.

Currently the intrastate division of the alcohol and drug abuse portion of the ADMS Block Grant from the mental health portion is based on the historical award of categorical grants to the State. State and community support is allocated with a recognition of the level of Federal support in certain areas. If the ADMS Block grant were to be divided into two new Block Grant programs and the Federal monies for these disabilities were reallocated to the States without a recognition of the historical award of grants, a disruption in services would occur in approximately one-half of the States unless additional funding was provided to soften the impact of this change.
(The State of Texas does not concur with this recommendation.)

5. Allocation Formula - No Consensus or Recommendation

The issue of allocation formulas is one on which a national organization that represents the States is typically unable to develop a consensus position. This reality is one which is applicable to not only the allocation formula for the ADMS Block Grant but also the supplemental treatment grants. What is clear, however, is that the issue of allocation formulas will be brought before the Congress during the renewal process.

More recently, the issue of the appropriateness of the dual allocation formula for the supplemental treatment grants has been discussed by Members of Congress. This is an issue which divides many members of our national association and one on which we are unable to reach a consensus.

6. Set-Asides in the ADMS Block Grant - No Consensus

As with the allocation formula, the NASADAD membership is unable to develop a consensus statement regarding the elimination or retention of all or individual set-asides in the ADMS Block Grant program. As a concept, set-asides do not appear to be conducive to a block grant approach, however, need for State discretion aside, individual set-asides have provided leverages for the use of Federal and State funds for specific programs and needs that many States had already identified, i.e. for women and prevention.

Although NASADAD is unable to reach a consensus on the removal of existing set-asides, NASADAD emphasizes the fact that any new set-asides which the Congress may consider will not be supported by NASADAD or the States unless these new intiatives are accompanied by adequate resources from the Federal level for implementation of the new program(s).

7. Inclusion of Congressional Findings and A Statement of Purpose for the ADMS Block Grant and Supplemental Treatment Grants in the Authorizing Statute

Currently, the authorizing statute for the ADMS Block Grant does not include a Statement of Purpose which clearly indicates why the Federal Government should provide support for the publicly-funded treatment and prevention system and delineates the types of services, initiatives and programs that are supported with those monies. NASADAD recommends the inclusion of Congressional Findings and a Statement of Purpose in the authorizing statute. (See attached Congressional Findings and Purpose.)

8. Recognition of the Need for Continuation and Improvement of Voluntary Data Collection Activities

All 50 States, the District of Columbia and the U.S. Territories participate in a uniform, voluntary data collection effort which provides information on an annual basis on treatment and prevention expenditures, client admissions, unmet needs and significant changes in the service delivery system. NASADAD recognizes the importance of continuing to conduct this valuable data collection effort. During recent deliberations on the development of a need and capacity formula for the allocation of the supplement treatment grants, it became apparent that there is a lack of certain indicator data on alcohol and drug abuse problems at the State and national level. It should be noted that the lack of these data is not due to an unwillingness of the States to participate in such a system, but due to a lack of resources within many of the States for the development, implementation, and maintenance of such a data system.

Therefore, NASADAD strongly recommends that any new Federal data initiatives must be accompanied by Federal resources and must provide for adequate input from and cooperation with the States on the definitions of and procedures related to data collection.

9. The Set-Aside of One Percent of the ADMS Block Grant Monies for Evaluation Purposes is Inappropriate and Unnecessary

ADAMHA is currently attempting to set-aside one percent of the national appropriation for the ADMS Block Grant program for evaluation activities to be conducted by ADAMHA. The precedent which would be set by this action is dangerous in that it permits the use of service monies for data collection and Federal research activities. If these monies are to be used to evaluate how the States are utilizing their ADMS Block Grant awards, it is not necessary since the States already provide annual reports on their expenditures of these monies, undergo independent State audits which are submitted to the Federal government and participate in numerous national surveys by independent groups and the General Accounting Office.

10. Removal of Prohibition Against Capital Construction

NASADAD recommends the removal of the current restriction against the use of ADMS Block Grant and supplemental treatment grant monies for capital construction. One of the most cost-effective means for accomplishing longterm expansion of treatment capacity is the purchase of physical plants or housing for treatment programs. In addition, many existing treatment programs will need to be renovated to provide for the expansion of services. Complete removal of this restriction or the potential for the inclusion of a limit on such costs will provide much needed flexibility to the States on the most appropriate mechanism for expanding and initiating new services.

NOTE: The above recommendations relate to the alcohol and drug portion of the ADMS Block Grant and the Supplemental Treatment Grants. Recommendations on the renewal of the mental health provisions of the ADMS Block Grant are not included in this document.

CONGRESSIONAL FINDINGS AND PURPOSE

The Congress finds that:

(1) Alcohol and drug abuse and dependency are major public health problems that are preventable and treatable;

(2) An estimated 18 million adults over the age of 18 are alcoholics or problem drinkers. In addition, an alarming number of youth under the age of 18 have problems with alcohol;

(3) There are over 18 million current users of marijuana and six million current users of cocaine;

(4) Alcohol abuse during pregnancy is one of the leading causes of mental retardation and the only one that is preventable;

(5) Over 60 percent of the cases of pediatric AIDS are related to intravenous drug use by one or both of the infant's parents. Over 25 percent of the individuals infected with the virus which causes AIDS are intravenous drug users.

(6) The economic costs of alcohol and drug abuse to society in 1983 alone were over $176 billion.

(7) Control of drug and alcohol abuse requires the development and maintenance of a comprehensive, coordinated long-term Federal strategy which supports effective health programs to prevent drug and alcohol abuse and to treat and rehabilitate victims of drug and alcohol abuse;

(8) Drug and alcohol abuse problems constitute a serious and continuing threat to national health and welfare, requiring an immediate and continuing effective response on the part of the Federal government;

(9) Alcoholism and drug addiction are illnesses requiring prevention, treatment and rehabilitation through the assistance of a board range of community health and social services and with the cooperation of law enforcement agencies, employers, employees associations, families and associations of concerned individuals;

(10) The prevention of drug and alcohol abuse problems is of paramount importance to the Federal government and requires the commitment of all levels of government and the participation of all members of the community.

It is the policy of the United States and the purpose of this Act to continue the Federal government's partnership with the States and local governments in the development, maintenance and improvement of the national network of comprehensive, community-based alcohol and drug abuse programs for our nation's citizens. The purpose of the alcohol and drug portion of this Act is to:

(1) Provide financial and technical assistance to the States and communities in their efforts to develop a core of prevention and treatment services for the purpose of significantly reducing the growing demand for alcohol and drug abuse treatment;

(2) Initiate and expand treatment and prevention services to underserved populations, such as youth, women, minorities and the homeless;

(3) Assist States and communities in their efforts to reach out to intravenous drug users, support their treatment needs and, therefore, to prevent their contracting and spread of the AIDS virus;

(4) Encourage the development and support of community-based prevention services and programs; and

(5) Emphasize the Federal commitment to demand reduction activities which seek to prevent and treat drug and alcohol abuse, drug addiction and alcoholism.

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